

WHILE I REMAIN IN USE CONTAINING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 997  
**FILED MAR 13 1940**

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Anthony's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis  
(c) City or town CLAYTON NR  
(If outside city or town limits, write "RURAL")  
(d) Street No. # 134 Linden Ave.,  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME EDWARD H. Keiser, Jr.

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Elizabeth 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Nov. 20 1861  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 2 29 hr. min.

9. Birthplace Allentown Pennsylvania  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Chemist

11. Industry or business \_\_\_\_\_

12. Name Bernard Keiser

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Pfeifer

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Katherine Keiser

(b) Address 134 Linden Ave

17. (a) Burial (b) Date thereof 2-21-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.,

19. (a) FEB 19 1940 (b) \_\_\_\_\_  
(Date received local registrar)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1940 day 7 Feb  
year 1940 hour 10 minute 59 A.M.

21. I hereby certify that I attended the deceased from February 7 to 1940  
that I last saw alive on Feb 19 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death lobar pneumonia Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions myocarditis  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address 2102 St. Louis Blvd Date signed Feb 19 1940

3550 Russell.

PR-6393

Hrs.-2:04 P.M.

---

---

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Clarence H. Murray*

Licensed Embalmer No. *4011*

P. O. Address *St. Louis, Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**