

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

100-6-17-39
REV. 6-17-39
1-21951

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.

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. Anthonys
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community 58 years
years, months or days

3. (a) PRINT FULL NAME Anna Kiefer
 3. (b) If veteran, name war no
 3. (c) Social Security No. no

4. Sex Female 5. Color or race Wht. 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Martin Kiefer 6. (c) Age of husband or wife if alive 67 years
 7. Birth date of deceased April 29 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	61	9	20	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business 7

MOTHER FATHER { 12. Name Joseph Rachota
 13. Birthplace Czechoslovakia
(City, town, or county) (State or foreign country)
 14. Maiden name Catherine Vesely
 15. Birthplace Czechoslovakia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Martin Kiefer
 (b) Address 2911 Gasconade

17. (a) Burial (b) Date thereof Feb. 22, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Old S. S. Peter & Paul

18. (a) Signature of funeral director Wm. C. Maydell
 (b) Address 1926 Allen Ave.

19. (a) FEB 21 1940 (b) J. P. [Signature]
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 2911 Gasconade
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? 58 Years _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 19
 year 1940 hour 4 00 minute _____ P. M.

21. I hereby certify that I attended the deceased from Jan 1
 _____, 19 40, to Feb 19, 19 40;
 that I last saw her alive on Feb 19, 19 40;
 and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocardites unknown
 Due to pericarditis of abdomen - unknown
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: generalized abdominal cancer
 Of operations _____
 Of autopsy no

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

23. Signature W. P. [Signature] (M. D. or other) MD
 Address 338 S. Grand Date signed 2-20-40

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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 Benj. C. Duncan

Licensed Embalmer No. 2272

P. O. Address 1926 Allen Ave

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. *4955*

Registrar's No. *1785*

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. *791*

Primary Registration District No. *1003-*

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME

Anna Kiefer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex *F*

5. Color or race *W*

6. (a) Single, widowed, married, divorced *M*

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

hours _____ minutes _____

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *H-19-40*

(Date received local registrar)

(b) *J. J. Bruckhoff*

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Feb.* day *14-40*
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____, to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the day and hour stated above.

Immediate cause of death *Chc. Myocarditis*
Carcinomatosis abdomen

Due to _____
Primary Seat. Abdominal Viscera

Due to *# N. M. R. #*

Other conditions _____
(Include pregnancy within 3 months of death) *4-6*

Major findings: *Gen. Abd. Cancer*

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 _____

Signature *J. A. Schneider* (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

