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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33740

Registration District No. 791 FILED NOV 16 1940

Primary Registration District No. 1003

Registrar's No. 8437

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

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: 5434 St. Louis Ave. 2
(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
(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL") 0
(d) Street No. 5434 St. Louis Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Katherine Kaiser
3. (b) If veteran, name war No.
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Joseph
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug. (Month) 8 (Day) 1856 (Year)
8. AGE: Years 84 Months 2 Days 1 If less than one day hr. min.
9. Birthplace Cape Girardeau (City, town, or county) Missouri (State or foreign country) 10
10. Usual occupation Housewife 4
11. Industry or business 16
MOTHER FATHER
12. Name William Blank
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Reubel
15. Birthplace Germany (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Elizabeth Traut
(b) Address 5434 St. Louis Ave.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-17-40 (Month) (Day) (Year)
(c) Place: burial or cremation Fieldon, Ill.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.
19. (a) NOV 11 1940 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 9th
year 1940 hour 8 1/2 minute P. M.
21. I hereby certify that I attended the deceased from June 15th, 1939, to Oct 9th, 1940 that I last saw her alive on Oct. 8th, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic myocarditis	
Due to	
Due to	
Other conditions (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 Chas E. Kaiser M.D. (or other) M.D.
Address 625 Missouri Ave. Date signed 10/17/40

(Licensed Embalmer's Statement on Reverse Side)

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 J. S. Sullivan

Licensed Embalmer No. 1122

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.