DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33871 8568

REC'D NOV 16 1940

Registration District No. 791 — Primary Registration District No. 1003 — Registrar's No.

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:
Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo 1 day (Specify whether years, months or days)
In this community 37 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St Louis 21
(If outside city or town limits, write "RURAL")

(d) Street No. 3054 a Thomas
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME George Kaiser

3. (b) If veteran, name war none

3. (c) Social Security No. 131759G

4. Sex Male

5. Color or race Colored

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased August (Month) 10 (Day) 1863 (Year)

8. AGE: Years 77 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Mintle Point (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER

12. Name Jerry Kaiser

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

14. Maiden name Mary Cook

15. Birthplace Four Shona (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Nurse McMurray

(b) Address 3740 W. Bell.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-40 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Bennie Love

(b) Address 3103 Washington Blvd.

19. (a) OCT 17 1940 (Date received local registrar) (b) J. B. Budlock (Registrar's deputy)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 13 year 1940 hour 2:34 minute A M.

21. I hereby certify that I attended the deceased from Sept 12, 1940, to October 13, 1940; that I last saw him alive on October 13, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypertrophy of Prostate Abt	1 yr
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature H. F. Fletcher (M. D. or other)

Address 2601 N Whittier Date signed 10/15/40

(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 Melvin Blackburn

Licensed Embalmer No. 3962

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, above space should be left blank.