

Registration District No. **759**

Primary Registration District No. **6000**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **ST CHARLES**
(b) City or town **RURAL CALHOUN TWP**
(c) Name of hospital or institution **MERIDIAN**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 MONTHS** (Specify whether years, months or days)
In this community **7 MONTHS**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **ST LOUIS**
(c) City or town **RURAL**
(If outside city or town limits, write "RURAL")
(d) Street No. **MERIDIAN** (If rural, give location)
(e) Citizen of foreign country? **(Yes or No)**
If yes, name country _____

3. (a) PRINT FULL NAME **CHRISTEN M. Kies**

3. (b) If veteran, name war **NO** 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 **LOTTIE KIES** 6. (c) Age of husband or wife if alive **17** years
7. Birth date of deceased **MARCH 17 1877** (Month) (Day) (Year)

8. AGE: Years **64** Months **7** Days **5** If less than one day hr. min.

9. Birthplace **JEFFERSON CO MO** (City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

11. Industry or business **SELF**

MOTHER FATHER { 12. Name **John Kies**
13. Birthplace **unknown GERMANY** (City, town, or county) (State or foreign country)
14. Maiden name **Julia Toy**
15. Birthplace **JEFFERSON CO MO** (City, town, or county) (State or foreign country)

16. (a) Informant **LOTTIE KIES**
(b) Address **MERIDIAN RD.**

17. (a) **CRURIAL** (Burial, cremation, or removal) (b) Date thereof **10-25-41** (Month) (Day) (Year)

(c) Place: burial or cremation **High Ridge Cem**

18. (a) Signature of funeral director **Robert M. Proctor**

(b) Address **overland mo**

19. (a) **10/25/41** (Date received local registrar) (b) **[Signature]** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **22** year **1941** hour **9** .01 minute **9** M.

21. I hereby certify that I attended the deceased from **Sept 15** 19**41** to **Oct 20** 19**41**; that I last saw him alive on **Oct 22** 19**41**; and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial infarction** Duration **10 days**
Due to **Arterio-sclerotic disease**

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **93d** 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 _____ (Specify type of place) (Specify type of injury) _____

23. Signature **[Signature]** (M.D. or other) _____
Address **Elkportville mo** Date signed **10/25/41**

607 (Licensed Embalmer's Statement on Reverse Side)

72000
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Carl L. Hillman

Licensed Embalmer No. *3501*

P. O. Address *Arvidrud wa.*

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, fact should be so stated above.