

S. No. 2  
M-1-4-41  
Rev. 5-17-39  
X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED OCT 28 1942  
Registration District No. 318

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003  
Primary Registration District No.

32115  
State File No.  
Registrar's No. 8619

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

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town ST LOUIS MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
AT HOME 4515 FLORA AVE 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 78 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000  
(a) State Mo (b) County \_\_\_\_\_  
(c) City or town ST LOUIS (If outside city or town limits, write "RURAL")  
(d) Street No. 4515 FLORA AVE 17 (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ANNA B. KIEFFER  
3. (b) If veteran, name war NONE  
3. (c) Social Security No. NONE

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 10 day 17 year 1942 hour 1 minute 29  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
that I last saw him 4 alive on Oct 4 1942 and that death occurred on the date and hour stated above.

4. Sex FEMALE / 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife PETER KIEFFER  
6. (c) Age of husband or wife if alive 79 years  
7. Birth date of deceased: AUG 15 1864  
(Month) (Day) (Year)

Immediate cause of death Carcinoma of the  
5 miles to size  
of liver & 1 1/2 in.  
Due to any pituitary  
glands  
Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
78 2 1 1 hr. 25 min.  
9. Birthplace ST LOUIS MO  
(City, town, or county) (State or foreign country)  
10. Usual occupation HOUSEWIFE

Other conditions (Include pregnancy within 3 months of death) No  
Major findings: Same as above  
Of operations 2 - 5/14/42  
Of autopsy None  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name THOMAS PATRICK BRENNAN  
13. Birthplace IRELAND  
(City, town, or county) (State or foreign country)  
14. Maiden name ELIZABETH KENNY  
15. Birthplace IRELAND  
(City, town, or county) (State or foreign country)

16. (a) Informant Heleen C. Keffer  
(b) Address 4515 FLORA AVE  
17. (a) BURIAL (b) Date thereof Oct 29 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial OLD ST PETER - PAUL  
18. (a) Signature of funeral director Walter Bookan  
(b) Address 6536 Clayton Rd  
19. OCT 17 1942 (b) J. F. Bredbeck  
(Date received local Registrar) (Registrar's signature)

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 Dominic M. Wade M.D. (M.D. or other)  
Address 1004 N. 1st St. St. Louis, Mo. signed 10/17/42

(Licensed Embalmer's Statement on Reverse Side)

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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.....

*J. G. Sullivan*

Licensed Embalmer No. *1122*

P. O. Address. *City*

**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.**