

S. No. 2  
A-1-4-41  
7-17-39  
X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

15428 ✓

State File No. \_\_\_\_\_

FILED MAY 6 1943 17

Registration District No. \_\_\_\_\_

Primary Registration District No. 6076

Registrar's No. 917

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Baden Station  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bellefontaine Nursing Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 Months  
(Specify whether years, months or days)

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Ferguson  
(If outside city or town limits, write "RURAL")

(d) Street No. 415 Harrison Ave.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME HENRY KALLER.

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Minnie Kaller. 6. (c) Age of husband or wife if alive Dec'd. years

7. Birth date of deceased February 27, 1859.  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

84 1 18 hr. min.

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

10. Usual occupation Retired Contractor.

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Dont know.

13. Birthplace Dont know. 9  
(City, town, or county) (State or foreign country)

14. Maiden name Dont know.

15. Birthplace Dont know. 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Alvina Reinhardt.

(b) Address 415 Harrison Ave.

17. (a) Burial (b) Date thereof 4-19-1943.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cemetery.

18. (a) Signature of funeral director Geo. L. Pleitsch Inc.

(b) Address 5966 Easton Ave.

19. (a) 4-17-43 (b) C. H. McLean, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15th.  
year 1943 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from March 15, 1943 to April 15, 1943  
that I last saw him alive on April 14, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hyperarteriosclerosis

Due to coronary arteriosclerosis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN

Major findings: Of operations \_\_\_\_\_

Of autopsy 938

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 Quincy Ross (M. D. or other) \_\_\_\_\_

Address 19189 Grand Date signed \_\_\_\_\_

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

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Dr. Emmy Ross.  
1918 East Grand.  
Hours 1 to 3 P.M.  
Telephone Central 4111

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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 3454

David C. Gibson....., Registered Apprentice No.....

working under my personal supervision.

Signed David C. Gibson.....

Licensed Embalmer No. 3454

P. O. Address 5766 Eastern St

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.