

S. No. 2
M-2-43
5-17-39
I X35867

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 282

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs. - 8 mos. 1 day
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 6530 Crest Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country. 0

3. (a) PRINT FULL NAME FRED ANTHONY KAISER

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race W.

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

6. (b) Name of husband or wife Elizabeth (Engle) Kaiser

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

7. Birth date of deceased September 23, 1869
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>8</u>	<u>20</u>	hr. _____ min.

9. Birthplace Cincinnati Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Plumbing & Building Inspector

11. Industry or business _____

12. Name Ferdinand Kaiser

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

14. Maiden name Minnie Roth

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

16. (a) Informant Records State Hospital No. 41

(b) Address Farmington, Mo.

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

(c) Place: burial or cremation Calvary Cem., St. Louis, Mo.

18. (a) Signature of funeral director James W. Clark

(b) Address 1125 Hodiemont Ave., St. Louis, Mo.

19. (a) 6-16-1943 (b) Tynde T. Hughes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13th
year 1943 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from May 4, 1943 to June 1943
that I last saw him alive on June 13, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arteriosclerosis
General sclerotic

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

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 J. J. Taylor (M. D. or other) MD
Address 408 W. Federal St Date signed 6/18/43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

1196

Farmington Mo.

RECEIVED

District Health Officer No. 4
District File Number 743-2370
Date Filed 7-6-43

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.....

me, Registered Apprentice No.....

working under my personal supervision.

Signed C. H. Cason

Licensed Embalmer No. 4084

P. O. Address Farmington, N.H.

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.