

FILED DEC 27 1943

Registration District No. 377

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town KOCH
(c) Name of hospital or institution: ROBERT KOCH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 232 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 11
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 2327 UNIVERSITY
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JACOB EDWARD KEISER

3. (b) If veteran, name war No. 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MARY DOE 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 10 - 15 - 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 2 4 hr. _____ min.

9. Birthplace ST. CHARLES CO. MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation SITOC WORKER

11. Industry or business _____

12. Name JACOB KEISER

13. Birthplace ST. CHARLES CO. MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name EMMA MOMOH COURT

15. Birthplace ST. CHARLES CO. MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant PATIENT

(b) Address _____
17. (a) Burial (b) Date thereof 12/22/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Celony Cemetery

18. (a) Signature of funeral director John A. Kelly & Son

(b) Address 929 N. Grand St.

19. (a) DEC 22 1943 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 19
year 1943 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from 4-27-43 to 12-19-43
that I last saw him alive on 12-19-43
and that death occurred on the date and hour stated above.

Immediate cause of death PULMONARY TUBERCULOSIS Duration 7yrs(?)

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 13/11
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?

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Samuel J. Kowalczyk (M. D. or other) _____
Address Robert Koch Hwy. - Koch, Mo. Date signed 12/19/43

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

MOTHER FATHER

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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.....
.....
working under my personal supervision.

Signed *John Goroehi* Registered Apprentice No.....
Licensed Embalmer No. *3398*
P. O. Address.....

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.