

State File No. ....

Registration District No. 335

Primary Registration District No. 4492

Registrar's No. ....

1. PLACE OF DEATH

(a) County Scott  
(b) City or town Drain  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 years  
In this community 2 years  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott  
(c) City or town DRAN  
(If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 1  
If yes, name country .....

3. (a) PRINT FULL NAME BERTHA KIEFER

3. (b) If veteran, name war — 3. (c) Social Security No. —

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife John H. Kiefer 6. (c) Age of husband or wife if alive 54  
7. Birth date of deceased Dec 17 1876  
(Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days 6 If less than one day hr. min.

9. Birthplace Scott Co. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business .....

MOTHER FATHER { 12. Name D.K.  
13. Birthplace (City, town, or county) (State or foreign country) 9  
14. Maiden name D.K.  
15. Birthplace (City, town, or county) (State or foreign country) 9

16. (a) Informant Rose M. Quoss  
(b) Address 4366 W. PINE, ST. LOUIS, MO

17. (a) (Burial, cremation, or removal) (b) Date thereof 2-25-1944  
(Month) (Day) (Year)  
(c) Place: burial or cremation Catholic Cemetery

18. (a) Signature of funeral director Heisner Funeral Home  
(b) Address Drain Mo

19. (a) (Date received local registrar) (b) 3/2/1944 (c) H. S. Chkman  
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 23  
year 1944 hour 3 minute 50 P.M.  
21. I hereby certify that I attended the deceased from JUNE 15  
1943 to Feb 23, 1944  
that I last saw her alive on Feb 22, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE Duration 6 mos.

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) gza!

Major findings: Of operations .....

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) 2

(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 H. S. Skellings (M. D. or other) MD  
Address Drain Mo Date signed 2/24/44

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

RECEIVED

District Health Office No. .

District File Number 344-416

Date Filed 3-3-44

**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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo

**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.**