S. No. 2
M—8-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 10579

Registration District No. FILED MAR 10 1945 Primary Registration District No. 3063 Registrar's No. 614

**1. PLACE OF DEATH:**

(a) County St Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 501 West Polo Drive
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Louis 96
(c) City or town Clayton 2
(If outside city or town limits, write "RURAL")
(d) Street No. 501 West Polo Drive 3
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 17

3. (a) PRINT FULL NAME Zona Kieffer Beisman
3. (b) If veteran, name war No.
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Paul Beisman
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov. 18, 1897 (Month) (Day) (Year)

8. AGE: Years 47 Months 3 Days 14 If less than one day hr. min.

9. Birthplace Perryville, Arkansas (City, town, or county) (State or foreign country)
10. Usual occupation At home
11. Industry or business Housewife
FATHER
12. Name Samuel I. Kieffer,
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Lora B. Morris
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Paul Beisman
(b) Address 501 West Polo Drive
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/45 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery,
18. (a) Signature of funeral director Robert J. Ambruster
(b) Address Clayton Rd. at Concordia Lane
19. (a) MAR 7 1945 (Date received local registrar) (b) E. G. McGAVRAN M.D. M.P.H. (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Mar day 2 year 1945 hour 11 minute 55 A.M.
21. I hereby certify that I attended the deceased from Mar 15, 1944 to Mar. 2, 1945 that I last saw her alive on Mar. 1, 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Carcinoma - adeno. | |
| Due to R. Breast | |
| Due to Metastases in Mediastinal Symphatics | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy None

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature [signature] (M.D. ~~or other~~)
Address Carlton Building. Date signed 3/3/45

(Licensed Embalmer's Statement on Reverse Side)

## 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.....

Licensed Embalmer No. 1994

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.**