

7. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

FILED JUN 9 1945

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
5355 Queens Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none
all of life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Sophia Kayser

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female **5. Color or** white **6. (a) Single, widowed, married,** Married
race white / divorced

6. (b) Name of husband or wife husband Ferdinand Kayser **(c) Age of husband or wife if** 59 years
alive

7. Birth date of deceased Dec. 25 1889
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>55</u>	<u>5</u>	<u>4</u>	hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

12. Name Joseph. Duepner

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

14. Maiden name Sophia Koehler

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

16. (a) Informant Ferdinand Kayser

(b) Address 5355 Queens Ave.

17. (a) Burial Calvary Cemetery **(b) Date thereof** 6/1/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director W. A. Stock

(b) Address 2117 E. Grand Blyd.

19. (a) MAY 31 1945 **(b)** J. F. Bredece
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5355 Queens Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
year 1945 hour 12:50 P. M. Minute M.

21. I hereby certify that I attended the deceased from April 5 - 1945 to May 29 1945
that I last saw er alive on May 29 1945
and that death occurred on the date and hour stated above.

Immediate cause of death General
encephalitis

Due to Primary carcinoma
of sigmoid

Due to Hb

Other conditions
(include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: Carcinoma of sigmoid

Of operations

Of autopsy

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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)

(c) Means of injury 0

23. Signature J. F. Bredece (M. D. or other)

Address 2045 N Grand Date signed 5/31/45

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. 3041

P. O. Address 2117 E. Grand

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.