

8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

39345

FILED JAN 5 1946

STANDARD CERTIFICATE OF DEATH 1003

State File No. 11308
Registrar's No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexian Bros Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 3 Weeks
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3733 Michigan
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22
year 1945 hour 10 minute 40 AM

21. I hereby certify that I attended the deceased from
Dec. 1945 to Dec. 22 1945
that I last saw him alive on Dec 22 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Chy. Nephritis (Hypertensive)
Hypertensive Essential

Duration

Due to Uremia
Due to

Other conditions
(Include pregnancy within 3 months of death)

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)
(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 0 - see d.

23. Signature L. H. Hayden (M. D. or other)
Address 5899 Delmar Date signed 12/24/45

3. (a) PRINT FULL NAME ALBERT A KAELIN

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bertha Kaelin 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased Feb 12 1898
(Month) (Day) (Year)

8. AGE: Years 47 Months 10 Days 10 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name Joseph Kaelin

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

14. Maiden name Antonina Kauflin

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

16. (a) Informant Bertha Kaelin

(b) Address 3333 Michigan

17. (a) Burial (b) Date thereof Dec 26/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New S.S. Peter & Paul

18. (a) Signature of funeral director Thos. J. ...

(b) Address 2805 Gray Ave.
DEC 25 1945
19. (a) (Date received local registrar) (b) (Registrar's signature)

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

MOTHER FATHER

Hayden
5897 Libman
430-2-30

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 *David Van Tassan*
Licensed Embalmer No. *4242*
P. O. Address *2906 Hamison*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11308

1. PLACE OF DEATH:

(a) County.....
(b) City or town Edwards
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Allegian Bros-Knop
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 wks
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Albert A Kaelin
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Feb 12 1898
(Month) (Day) (Year)

8. AGE: Years 47 Months 8 Days 18 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business Brewery worker

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) JAN 17 1948 J. F. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 22 Year 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....
that I last saw him..... alive on....., 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

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

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)

(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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

1000 1000

39345