

S. No. 2
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5-17-39
P 1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31280**
Registrar's No. **1968**

FILED SEP 30 1946
Registration District No. **379**

Primary Registration District No. **3063**

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

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: St. Louis Co. Hosp. 0
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution 16 days
(Specify whether years, months or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis County 76
(c) City or town Dieche
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME KAYSING, Sophie
3. (b) If veteran, name war =
3. (c) Social Security No. =

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 19th
year 1946 hour 3 minute 50 A.M.

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife deceased
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 7 24 73
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from September 3 1946, to September 19 1946;
that I last saw her alive on September 19 1946, and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 1 Days 25
If less than one day hr. _____ min. _____

Immediate cause of death Pneumonia, terminal Duration _____

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

Due to suppurated cerebral thrombosis due to generalized arteriosclerosis
Due to 638

10. Usual occupation Housewife

Other conditions right hemiplegia
(Include pregnancy within 3 months of death)

11. Industry or business _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name Moritz Koch
13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Wilhelmina Kalle
15. Birthplace Hanover Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Herman Koch
(b) Address Dieche, Mo

17. (a) BURIAL (b) Date thereof SEPT. 21, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SUNSET BURIAL PARK

18. (a) Signature of funeral director Edward J. Zimm
(b) Address 1936 N. Pauline

19. (a) 9-19-46 (b) Ruth A. Allen MD
(Date received local registrar) (Registrar's signature)

Major findings: _____
Of operations _____
Of autopsy _____

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 6
23. Signature John Haffey (M. D. or other) MD
Address 601 Brentwood Blvd Clayton Date signed _____

JUL 10 1966

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 Glen E. Hag

Licensed Embalmer No. 3737

P. O. Address 1936 St. Louis

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.