

Registration District No. **310**

Primary Registration District No. **3028**

Registrar's No. **96**

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

1. PLACE OF DEATH:
 (a) County St. Charles
 (b) City or town Cottleville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(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

3. (a) PRINT FULL NAME Isabelle E. Kasper
 (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F / 5. Color or race W
 6. (a) Single, widowed, married, Married
 6. (b) Name of husband or wife Shade Kasper
 6. (c) Age of husband or wife if alive 56 years
 7. Birth date of deceased May 24 1893
(Month) (Day) (Year)

8. AGE: Years 54 Months 0 Days 7
 If less than one day _____ hr. _____ min.

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

10. Usual occupation House work

11. Industry or business
MOTHER FATHER
 { **12. Name** Weber
13. Birthplace St. Charles Mo.
(City, town, or county) (State or foreign country)
 { **14. Maiden name** Schappe
15. Birthplace St. Peters Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Shade Kasper
 (b) Address Cottleville Mo

17. (a) Burial (b) Date thereof 6 3 '47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Cottleville Mo

18. (a) Signature of funeral director Frank E. Kelly
 (b) Address Ofallon Mo.

19. (a) 6-4-47 (b) Pennie Hamilton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County St. Charles
 (c) City or town Cottleville Mo
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? No years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 31
 year 1947 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from
Jan 1939 to May 10 1947;
 that I last saw her alive on May 10 1947;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy
 Duration 2 hours

Due to Hypertension 10 yrs

Due to _____

Other conditions generalized arteriosclerosis 4 yrs
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 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:

(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? 0

While at work? _____
(Specify type of place)
 (e) Means of injury _____

23. Signature George E. Kistner (M. D. or other) MD
 Address St. Charles, Mo Date signed 6-4-47

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed MIN 27 1947

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 E. K. Smith
Licensed Embalmer No. 877
P. O. Address Dallan 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, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. June94Registration District No. 310Primary Registration District No. 3058

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County St Charles
 (b) City or town Cottleville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(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)3. (a) PRINT FULL NAME Isabelle E. Kasper

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

7. Birth date of deceased
- May 24 1929
-
- (Month) (Day) (Year)

8. AGE: Years
- 54
- Months _____ Days _____ 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 _____

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) _____ (b) Date thereof _____
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a)
- June 4, 1994
- (b)
- Francis Howell
-
- (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- 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 _____ Year
- 1994
- 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 _____

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

18509.