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5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36467
Registrar's No. 2280

Registration District No. 317

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(c) Name of hospital or institution: St. Louis Co. Hospital
(d) Length of stay: In hospital or institution (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Elizabeth Kaiser

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

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

6. (b) Name of husband or wife Rudolph Kaiser 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased April 13, 1912
(Month) (Day) (Year)

8. AGE: Years 35 Months 5 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Anthony Kasycki

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

14. Maiden name Josephine Koroeski

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

16. (a) Informant Rudolph Kaiser

(b) Address 6549 Joseph Ave.,

17. (a) Burial (b) Date thereof Oct. 15/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cem.,

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave.

19. (a) 10-21-47 (b) Paul J. Hayes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town Wellston
(d) Street No. 6549 Joseph Ave.,
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12
year 1947 hour 4.00 minute P.M.

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

Immediate cause of death Pulmonary Tuberculosis Duration 10 yrs
Due to _____

Due to 138
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy yes

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?

Signature Paul J. Hayes (Specify type of place) (e) Place of injury _____
Address Commissioner of Health Date signed 10-11-47

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

MOTHER FATHER

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..... *Alfred J. Boedecker*.....
Licensed Embalmer No..... 2663.....

P. O. Address..... 1125 Hodiament Ave.,.....

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.

Registration District No. 317

Primary Registration District No. 3063

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:
(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

Elizabeth Kaiser

(b) If veteran, name war _____

(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 _____

7. Birth date of deceased April 13
(Month) (Day) (Year)

8. AGE: Years 35 Months _____ Days _____ (if less than one day)
hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) _____ (b) Gene Slay
(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 _____
year 1942 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 _____

Due to _____

Due to _____

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

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—NOV 22 1947 PERMANENT RECORD

ENCLOSED

S-36467