

No. 300
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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED FEB 28 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6561**
Registrar's No. **1567**

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

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:
1409 Benton St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 52 years
years, months or days

3. (a) PRINT FULL NAME Minnie A. Kaeshoefer
3. (b) If veteran, name war none 3. (c) Social Security No. none
4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife John Kaeshoefer 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased November 25th, 1877
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>2</u>	<u>20</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Isaac Newton
13. Birthplace Wis
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Baughman
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant John Kaeshoefer
(b) Address 1409 Benton St.

17. (a) Burial (b) Date thereof 2-18-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Hy. Leidner U. Co.
(b) Address 2223 St. Louis Ave.

19. (a) FEB 6 1948 (b) J. J. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County C
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1409 Benton St.
26 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15
year 1948 hour 12:00 minute None M.

21. I hereby certify that I attended the deceased from Jan. 15, 1948 to Feb. 15, 1948
that I last saw her alive on Feb. 14, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral embolus - affecting left side brain
Due to Thrombo-phlebitis

Due to Diabetes

Other conditions 61-
(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 J. C. Creaner (M. D. or other) MD
Address 2804 N. 18th St. Date signed 2-16-48

Duration

1 wk

1 month

10 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

4-1-57 10:00

0-1176

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 *John P. Buchholz*
Licensed Embalmer No. *1674*
P. O. Address *2223 H. Lewis av*

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.