

FILED APR 3 1948  
Registration District No. **310**

Primary Registration District No. **1003**

1. PLACE OF DEATH: **310**

(a) County **ST. LOUIS MO**  
 (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 **1 DAY**  
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **000**  
 (c) City or town **ST. LOUIS** **19**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **3715 MISSOURI** **9**  
**24** (If rural, give location)  
 (e) Citizen of foreign country? **0** (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Joseph KESSLER**  
 (b) If veteran, name war \_\_\_\_\_  
 (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAR.** day **19**  
 year **1948** hour **11** minute **45 A.M.**

4. Sex **0** **MALE** 5. Color or race **WHITE**  
 6. (a) Single, widowed, married, divorced **MARRIED**  
 (b) Name of husband or wife **EMILY** 6. (c) Age of husband or wife if alive **58** years  
 7. Birth date of deceased **FEB. 13 1886**  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **March 18**, 19**48**, to **March 19**, 19**48**;  
 that I last saw him alive on **March 19**, 19**48**;  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**62** **1** **6** hr. min.

Immediate cause of death **Sub. dual hemorrhage** **1 day**  
 Due to **Undermined**  
 Due to **Acute hepatitis** **2 day**  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace **ST. LOUIS MO A**  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation **GENERAL CONTRACTOR**

Major findings: Of operations \_\_\_\_\_  
 Of autopsy **Sub. dual hemorrhage**  
**into South Ventricle**  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
 12. Name **IGNATZ KESSLER**  
 13. Birthplace **GERMANY 4**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **CAROLINE LAMBERT**  
 15. Birthplace **UNKNOWN A**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **EMILY KESSLER**  
 (b) Address **3715 MISSOURI**  
 17. (a) **BURIAL** (b) Date thereof **MAR 22 1948**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **RESURRECTION CEM**

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? \_\_\_\_\_

18. (a) Signature of funeral director **Thomas Kutis & Son**  
 (b) Address **2906 GRAVOIS**  
 19. (a) **MAR 21 1948** (b) **J. F. Brudner**  
 (Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury **0**  
 23. Signature **Julius Ch. Koles** (M. D. or other) **M.D.**  
 Address **2603 Clarke St** Date signed **3-20-48**

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

10  
7  
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**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 James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 Travis

**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.**