

FILED OCT 1 1948 **318**  
Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County St Louis Mo.  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Hosp - 10  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County St Louis  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3225 MONTGOMERY  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Michael KAESMORIN  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 11th day Sept  
year 1948 hour 4:40 minute P. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced SINGLE  
7. Birth date of deceased Oct 29 - 1872  
(Month) (Day) (Year)

Immediate cause of death  
Chronic Myocarditis  
Chronic Interstitial Nephritis  
Due to \_\_\_\_\_  
Due to 1/2/48  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 75 Months 10 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Poland  
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER  
11. Industry or business \_\_\_\_\_  
12. Name MORGAN KAESMORIN  
13. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)  
14. Maiden name UNKNOWN  
15. Birthplace Poland  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant MARGARET KELLY  
(b) Address 2331 MULLANPHY  
17. (a) BURIAL (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation CALVARY  
18. (a) Signature of funeral director G. J. F. Breda  
(b) Address 4386 Lindell  
19. (a) SEP 17 1948 (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury 3  
Signature Patrick B. Taylor (M.D. or other) Dep Car  
Address 1300 Clark Date signed 9-17-48

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

**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 Ralph W. Henson

Licensed Embalmer No. 3791

P. O. Address St. Louis, 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, fact should be so stated above.**