

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10244

State File No. 2549
Registrar's No. 1003

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Mo.</u> b. COUNTY <u>040</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>17</u> d. STREET ADDRESS (If rural, give location) <u>4500 Chouteau Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>NANCY</u> b. (Middle) <u>ANN</u> c. (Last) <u>KALER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 19 1949</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb. 14, 1862</u>
9. AGE (In years last birthday) Months Days <u>87 1 5</u>		IF UNDER 1 YEAR Hours Min. <u>1 5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <u>Edward Bobbett</u>	
13b. MOTHER'S MAIDEN NAME <u>Rebecca Gibbons</u>		14. NAME OF HUSBAND OR WIFE <u>Late John Kaler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Dr. Frank T. Grice</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Ruptured Dangerous Appendix</u> ANTECEDENT CAUSES <u>2 Pelvic Abscess</u> DUE TO (b) <u>Generalized Peritonitis</u> DUE TO (c) <u>Cirrhosis of Liver - strain in lead</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of Left Breast - metastatic</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 weeks</u> <u>5 1/2 weeks</u> <u>3 years</u> <u>3 years</u>		19a. DATE OF OPERATION <u>2-16-49</u>	
19b. MAJOR FINDINGS OF OPERATION <u>Ruptured dangerous appendix & generalized peritonitis</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2-15, 1949</u> to <u>3-19, 1949</u> , that I last saw the deceased alive on <u>3-19, 1949</u> , and that death occurred at <u>10:55 P m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>J. M. Webb M.D.</u>		23b. ADDRESS <u>4501 1/2 Manchester</u>	23c. DATE SIGNED <u>3-21-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (Mtr)</u>	24b. DATE <u>Mar. 22, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <u>Fairfield, Ill.</u>
DATE RECEIVED BY LOCAL REGISTRAR'S SIGNATURE <u>J. B. Sasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kriegshauser 4228 S. Kingshighway Bl.</u>	

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Edwin M. Herriott

Signed _____
Student Embalmer

Licensed Embalmer No. 3024

P. O. Address _____

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.