

FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 24993  
6751

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No.
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. LENGTH OF STAY (in this place) 3 weeks		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If rural, give location) 4553 Durant Ave.		
3. NAME OF DECEASED (Type or Print) a. (First) Josephine		b. (Middle)		c. (Last) Kieffer
4. DATE OF DEATH (Month) (Day) (Year) August 1 1949				
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH January 30, 1879	9. AGE (In years last birthday) 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Luxembourg
12. CITIZEN OF WHAT COUNTRY?				
13a. FATHER'S NAME Carl Fournelle		13b. MOTHER'S MAIDEN NAME Mary Weisgerber		14. NAME OF HUSBAND OR WIFE August Kieffer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME August Kieffer ADDRESS 4553 Durant Ave.
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Acute Dilatation, Mitral Regurgitation 7 mos Antecedent Causes Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes Chronic Nephritis 2 yrs. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis, Mo.		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR Med X		
22. I hereby certify that I attended the deceased from Jan. 1947, to Aug. 1, 1949, that I last saw the deceased alive on Aug. 1, 1949, and that death occurred at 9:10 p. m., from the causes and on the date stated above.				
23a. SIGNATURE (Name or title) Bernard F. Chesel M.D.		23b. ADDRESS		23c. DATE SIGNED 8/2/49
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 8-4-49	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery.	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri.	
DATE REC'D BY LOCAL REG. 4063	REGISTRAR'S SIGNATURE J. B. Losater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Math Hermann & Son, Inc. 2161 E. Fair Ave.		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Homer W. Fritz

Licensed Embalmer No. 3882

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.