

FILED MAR 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10002

State File No.

0423
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BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Charles</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural-St. Charles Township</u>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <u>R.R. #2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Anna</u>		b. (Middle) <u>Louise</u>	
		c. (Last) <u>Kisker</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>February 22, 1950</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 11, 1871</u>
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u>11</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>St. Charles, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>William Boenker</u>		13b. MOTHER'S MAIDEN NAME <u>Helene Meyer</u>	14. NAME OF HUSBAND OR WIFE <u>Herman Kisker</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. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Edwin Kisker - St. Charles, Mo.</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>Broncho pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Gen. Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture Rt Femur</u>	
19a. DATE OF OPERATION <u>2/6/50</u>		19b. MAJOR FINDINGS OF OPERATION <u>inter trochanteric fracture Rt femur</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 days</u> <u>10 yrs</u> <u>20 DAYS</u>	
21a. ACCIDENT SUICIDE HOMICIDE <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) <u>R.R. #2 St. Charles</u>	(STATE) <u>MO 672</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>2/2/50 12:30 PM</u>	21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fell down on floor in home</u>	
22. I hereby certify that I attended the deceased from <u>8/22/1946</u> , to <u>10/22/1950</u> , that I last saw the deceased alive on <u>10/22/1950</u> , and that death occurred at <u>10:25 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>R. J. Buckie O.M.U.</u>		23b. ADDRESS <u>1216 So. Main St. St. Charles, Mo.</u>	
23c. DATE SIGNED <u>2/24/50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb. 25, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Zion Luth. Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Charles County, Mo.</u>
DATE REC'D BY LOCAL REG. <u>3/2/50</u>	REGISTRAR'S SIGNATURE <u>Thomas H. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas H. ... St. Charles, Mo.</u>	

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

District File Number
District Health Officer No. 9,
RECEIVED MAR 10 1950

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 Charles J. Nacke

Licensed Embalmer No. 4530

P. O. Address St. Charles, 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.