

FILED APR 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10650**
Registrar's No. **1968**

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

| | | | |
|---|-----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | c. LENGTH OF STAY (In this place) | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City 4330 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital | | d. STREET ADDRESS (If rural, give location) 747 Syracuse | |

| | | | | | |
|-------------------------------------|-------------|-------------------------|---------------------------------------|-----|------|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH (Month) (Day) (Year) | | |
| a. (First) REBECCA | b. (Middle) | c. (Last) KAISER | FEB. | 27, | 1950 |

| | | | | | | | | |
|----------------------|-------------------------------|---|---------------------------------|--|------------------------|----------------------|-----------------------|----------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH Unknown | 9. AGE (In years last birthday) Abt. 85 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 YEAR Hours | IF UNDER 1 YEAR Min. |
|----------------------|-------------------------------|---|---------------------------------|--|------------------------|----------------------|-----------------------|----------------------|

| | | | | | |
|--|--|-----------------------------------|---|--|---------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? 6 |
|--|--|-----------------------------------|---|--|---------------------------------------|

| | | | | | |
|-----------------------------------|--|--|--|---|--|
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Abraham Kaiser | |
|-----------------------------------|--|--|--|---|--|

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|--|-------------------------|---|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) no | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. M. Leventhal-747 Syracuse | | | |
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| | | | | | |
|--|--|--|--|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) | | Chronic Myocarditis | | | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | ANTECEDENT CAUSES | | | |
| | | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | |
| | | DUE TO (b) | | | |
| | | Chronic Interstitial | | | |
| | | DUE TO (c) | | | |
| | | Nephritis | | | |
| II. OTHER SIGNIFICANT CONDITIONS | | Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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|------------------------|----------------------------------|--|--|---|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) |
|--|--|---|

| | | |
|--|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 592X |
|--|--|--|

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **5:20 A** m., from the causes and on the date stated above.

| | | |
|--|--------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) Catrick E Taylor, M.D. | 23b. ADDRESS 1300 Clark | 23c. DATE SIGNED 2-28-50 |
|--|--------------------------------|---------------------------------|

| | | | |
|---|--------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 2/28/50 | 24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem | 24d. LOCATION (City, town, or county) (State) St. Louis, Missouri |
|---|--------------------------|---|--|

| | | |
|---|---|---|
| DATE REC'D BY LOCAL REG. FEB 28 1950 | REGISTRAR'S SIGNATURE J. B. Lassiter | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John... 5216 Delmar |
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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.....

.....
working under my personal supervision.

Signed.....
Student Embalmer

No Embalming
Signed *Herman Rindke*
Licensed Embalmer No.

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.