

FILED JUN 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21688

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5331

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS, MISSOURI</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. LENGTH OF STAY (If this place) <u>3 DAYS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		2059				
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>BARNES HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>5465 CABANNE AVE</u>						
3. NAME OF DECEASED (Type or Print) a. (First) <u>ALMA</u> b. (Middle) <u>MARIE</u> c. (Last) <u>KEISER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 16, 1950</u>							
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>JANUARY 7, 1883</u>		9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WELDON SPRINGS, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>JOHN KEISER</u>			13b. MOTHER'S MAIDEN NAME <u>SUSAN MILLER</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</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 <u>MRS. EMIL BRILL</u>				ADDRESS <u>7815 DAVIS DRIVE</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>Asthenia-sclerotic Heart Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pulmonary Tuberculosis</u> 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 <u>7 yrs.</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" 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.) <u>D</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>D</u>						
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? <u>ROTX</u>						
22. I hereby certify that I attended the deceased from <u>JUNE 13, 1950</u> , to <u>June 16, 1950</u> , that I last saw the deceased alive on <u>JUNE 16, 1950</u> , and that death occurred at <u>1:55P</u> m., from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) <u>Ralph H. Forrester M.D.</u>				23b. ADDRESS <u>Barnes Hospital</u>			23c. DATE SIGNED <u>6-16-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>6/19/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>EVANGELICAL & REFORMED CHURCH CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>WELDON SPRINGS, MO.</u>					
DATE REC'D BY LOCAL REG. <u>JUN 19 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C R LUPTON AND SONS</u>					ADDRESS <u>7233 DELMAR BLVD</u>	

(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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Clarence H. Murray*

Licensed Embalmer No. *4011*

P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.