

FILED OCT 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31491

BIRTH NO. 134 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 4462 Registrar's No. 322

1. PLACE OF DEATH a. COUNTY <i>St. Francois</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before adoption). a. STATE <i>Missouri</i> b. COUNTY <i>St. Francois</i>	
b. CITY OR TOWN <i>Elvins</i>		c. CITY OR TOWN <i>Elvins, Mo.</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <i>Michael</i> b. (Middle) <i>D.</i> c. (Last) <i>Kaiser</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>Sept. 26, 1950</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Never Married</i>	8. DATE OF BIRTH <i>Nov. 5, 1944</i>	9. AGE (In years last birthday) <i>5</i>	10. MONTH <i>10</i> DAY <i>27</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Mo.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					

13a. FATHER'S NAME <i>Lindell Kaiser</i>	13b. MOTHER'S MAIDEN NAME <i>Ruth King</i>	14. NAME OF HUSBAND OR WIFE <i>None</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT'S SIGNATURE OR NAME <i>Ruth Kaiser</i>	ADDRESS <i>Elvins, Mo.</i>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Branch Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
	ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		
	DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			<i>49ix</i>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from *Sept 25, 1950*, to *Sept 26, 1950*, that I last saw the deceased alive on *Sept 25, 1950*, and that death occurred at *7:00 a.m.*, from the causes and on the date stated above.

23a. SIGNATURE <i>Lu Stimpel M.D.</i>	(Degree or title)	23b. ADDRESS <i>Farmer's Office</i>	23c. DATE SIGNED <i>9/26/50</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>9/27-50</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Parkview Cemetery</i>	24d. LOCATION (City, town, or county) (State) <i>Near Farmington, Mo.</i>
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DATE REC'D BY LOCAL REG. <i>Sept. 26, 1950</i>	REGISTRAR'S SIGNATURE <i>Ethel Rudolph</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond Caldwell</i>	ADDRESS <i>Flat River, Mo.</i>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

941

DISTRICT HEALTH OFFICE NO. 4

File No.

OCT - 2 1950

RECEIVED

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

not embalmed

Student Embalmer No.

Signed

R. Caldwell

Signed.....
Student Embalmer

Licensed Embalmer No. 2531

P. O. Address Flat River, 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.