

FILED NOV 17 1950

STANDARD CERTIFICATE OF DEATH

State File No. 39172
Registrar's No. 8475

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	
c. LENGTH OF STAY (in this place) 36 yrs		2199	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4315 LINDELL		d. STREET ADDRESS (If rural, give location) 4315 LINDELL	

3. NAME OF DECEASED (Type or Print) a. (First) Estelle b. (Middle) c. (Last) White		4. DATE OF DEATH (Month) (Day) (Year) OCT 7, 1950	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH unk
9. AGE (In years last birthday) 40 36		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	11. BIRTHPLACE (State or foreign country) ST. LOUIS
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY -	12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Julius KAISER	13b. MOTHER'S MAIDEN NAME Annie Krause	14. NAME OF HUSBAND OR WIFE James
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sol KAISER 7361 1/2 Thru

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chloroform poisoning</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>whether accidental or suicidal could not be</u> DUE TO (c) <u>determined</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Open Verdict	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) Verdict	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 60219
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? 6/18/50

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 2:45 P. m., from the causes and on the date stated above.

23a. SIGNATURE Cathie E Taylor Coroner	(Degree or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 10-8-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/9/50	24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Smith	24d. LOCATION (City, town, or county) (State) Annect W. Mo.
DATE REC'D BY LOCAL REG. OCT. 8 1950	REGISTRAR'S SIGNATURE J.P. Kestee	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Beige Memorial 4215 Mt. Pleasant	

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.....

Quinn J. Quiring

Licensed Embalmer No. *4829*

Signed.....

Student Embalmer

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.