

FILED FEB 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3259

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 4464 Registrar's No. 213

1. PLACE OF DEATH a. COUNTY St. Louis		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) Overland		c. CITY (If outside corporate limits, write RURAL and give township) Overland	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3305 Dix Ave		d. STREET ADDRESS (If rural, give location) 3305 Dix Ave	

3. NAME OF DECEASED (Type or Print)	a. (First) Nellie	b. (Middle) E	c. (Last) Kaiser	4. DATE OF DEATH (Month) (Day) (Year) Jan 24 1951
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5. SEX Female	6. COLOR OR RACE W...	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 24 1871	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ireland	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Daniel O'Rourke	13b. MOTHER'S MAIDEN NAME Mary Ellen Colman	14. NAME OF HUSBAND OR WIFE Wm. E. Kaiser
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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) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Wm. E. Kaiser	ADDRESS 3305 Dix Ave
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chr. Myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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	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 **Oct 23 11:15** to **Jan 24, 1951**, that I last saw the deceased alive on **Jan 24, 1951**, and that death occurred at **m.** from the causes and on the date stated above.

23a. SIGNATURE M. A. DeLuca M.D. (Degree or title)	23b. ADDRESS 8924 St. Charles St. St. Louis 14 Mo	23c. DATE SIGNED 1/25/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 27 1951	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) St. Louis Mo. (State)
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DATE REC'D BY LOCAL REG. 1/25/51	REGISTRAR'S SIGNATURE Hubert Robinson M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Jos. W. Clark	ADDRESS 1125 Modiamont Ave
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

box 1

D. M. & Diethe
8924th - Atchafalaya

Rock
Road

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 James Bensley
Licensed Embalmer No. 3653

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.