

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24850**

FILED JUL 26 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003** Registrar's No. **6269**

1. PLACE OF DEATH a. COUNTY <b>0</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. LENGTH OF STAY (In this place) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>	
3. NAME OF DECEASED (Type or Print) <b>CAROLINE</b>		d. STREET ADDRESS (If rural, give location) <b>3454 Ohio Av. 0</b>	
a. (First) _____		b. (Middle) _____	
c. (Last) <b>KIERAN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>JULY-12-51</b>	
5. SEX <b>FE. /</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>M. /</b>	8. DATE OF BIRTH <b>DEC-24-1893</b>
9. AGE (In years last birthday) <b>57YR</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>ST. LOUIS MO P.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOHN MAURER</b>		13b. MOTHER'S MAIDEN NAME <b>URSULA</b>	
14. NAME OF HUSBAND OR WIFE <b>OWEN KIERAN</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Owen Kieran</b> ADDRESS <b>3454 Ohio Av.</b>	
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) <b>Uremia</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Generalized calcinosis</b> DUE TO (c) <b>Purify. Ca of Rectum</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <b>10-23-45</b>		19b. MAJOR FINDINGS OF OPERATION <b>Ca of Rectum (abdominal peritonitis)</b>	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>154X</b>		22. I hereby certify that I attended the deceased from <b>10-13</b> , 19 <b>45</b> , to <b>7-12</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>10-13</b> , 19 <b>45</b> , and that death occurred at <b>11:25 pm.</b> , from the causes and on the date stated above.	
23a. SIGNATURE <b>William W. Foley</b> (Degree or title) <b>med.</b>		23b. ADDRESS <b>3008 Sogard</b>	
23c. DATE SIGNED _____		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
24b. DATE <b>JULY-16-51</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Schmir</b> ADDRESS <b>3125 Lafayette</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>J. B. Coaster</b>		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE _____	

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 \_\_\_\_\_

*John Bollmer*

Licensed Embalmer No. *4414*

P. O. Address *3195 Lafayette St*

Signed.....  
Student Embalmer

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.