

31198

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300

10-48

FILED SEP 15 1951

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 175

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Warren	
b. CITY OR TOWN St. Charles		c. CITY OR TOWN Marthasville Rural	
c. LENGTH OF STAY (in this place) 2-days		d. STREET ADDRESS (If rural, give location) R#1	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Lottie	b. (Middle) Kies	c. (Last)	(Month)	(Day)	(Year)
			Aug.	30.	1951

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Dec. 16, 1887	9. AGE (In years last birthday) 61	Months 8	Days 14	IF UNDER 24 HRS. Hours Min.
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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 Home	11. BIRTHPLACE (State or foreign country) Valley Park, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Fitzhugh Boren	13b. MOTHER'S MAIDEN NAME Laura Comer	14. NAME OF HUSBAND OR WIFE Chris Kies Dcd.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Ralph Ramey	ADDRESS Marthasville, Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH 2 days.
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Ecthymoid l. eye.		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT ✓ (Specify) SUICIDE HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Marthasville Warren Mo
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8 28 51 A.M.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fell down steps.
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22. I hereby certify that I attended the deceased from **8/28**, 1951, to **8/30**, 1951, that I last saw the deceased alive on **8/30**, 1951, and that death occurred at **2:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE B. L. Heberlein, M.D.	(Degree & title)	23b. ADDRESS St. Charles, Mo.	23c. DATE SIGNED 8/31/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-1-1951	24c. NAME OF CEMETERY OR CREMATORY St. Martin Cemetery	24d. LOCATION (City, town, or county) (State) High Ridge, Mo.
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DATE REC'D BY LOCAL REG. 9-3-51	REGISTRAR'S SIGNATURE Frank Hamilton	25. FUNERAL DIRECTOR'S SIGNATURE Bannmann	ADDRESS 2504-Woodson Rd-Overland, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

File No. _____
DISTRICT HEALTH OFFICE No. 4

SEP 10 1951

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Oscar F. Mueller

Licensed Embalmer No.

3039

P. O. Address

Overland 14 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.