

No. 300  
10. 48

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 35271  
Registrar's No. 9158

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <b>2249</b>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <b>St. Anthony Hospital, 3520 Chippewa St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Anthony's Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Sister M. Isabel</b> b. (Middle) <b>O.S.F.</b> c. (Last) <b>(Anna Kieffer)</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>October 15, 1951</b>		
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5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>		8. DATE OF BIRTH <b>2/10/1874</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry Manager</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Religious Sister</b>			11. BIRTHPLACE (State or foreign country) <b>Fredonia Ozaukee County, Wisc.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13a. FATHER'S NAME <b>Nicolaus Kieffer</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Steinmetzer</b>		14. NAME OF HUSBAND OR WIFE	
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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) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <b>St. Anthony's Hospital</b>		ADDRESS <b>3520 Chippewa St.</b>	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of neck</b>  ANTECEDENT CAUSES Morbidity 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. <b>Arteriosclerosis General</b>				INTERVAL BETWEEN ONSET AND DEATH <b>about 1 year</b>	
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19a. DATE OF OPERATION <b>11/18/50</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of neck</b>				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)	
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>199K</b>	

22. I hereby certify that I attended the deceased from 11-18, 1950, to 10-15, 1951, that I last saw the deceased alive on 10-15, 1951, and that death occurred at 1:25 P.M., from the causes and on the date stated above.

23a. SIGNATURE <b>Robert G. Warner M.D.</b>		23b. ADDRESS <b>Paul Brown Bldg St. Louis</b>		23c. DATE SIGNED <b>Oct 17 51</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>October 18, 1951</b>		24c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
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DATE REC'D BY LOCAL REG. <b>OCT 17 1951</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Gebken-Benz Mortuary</b>		ADDRESS <b>2842 Meramec St.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

St. Louis, 18 Mo.

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 me

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Loren E. Sencig

Signed.....  
Student Embalmer

Licensed Embalmer No. 40940

P. O. Address 2842 Meramec St.  
St. Louis, 18 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.