

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15935**
REG. DIST. NO. **77** PRIMARY REG. DIST. NO. **3016** Registrar's No. **128**

0264
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

250 JUN 7 1952
BIRTH NO.

1. PLACE OF DEATH a. COUNTY Cole		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE Missouri b. COUNTY Cole	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jefferson City	c. LENGTH OF STAY (In this place) 8 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 107-Fulkerson 6264	
d. FULL NAME OF HOSPITAL OR INSTITUTION 107-Fulkerson		d. STREET ADDRESS (If rural, give location) Jefferson City	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Ann c. (Last) Kaiser	4. DATE OF DEATH (Month) (Day) (Year) June 2 1952
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Dec. 23, 1861	9. AGE (In years last birthday) 90 IF UNDER 1 YEAR: Months 5 Days 10 IF UNDER 1 MRS. Hours 5 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 At Home	11. BIRTHPLACE (City and State or Foreign Country) Wisconsin	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Seeberger	13b. MOTHER'S MAIDEN NAME Mary Ann Walters	14. NAME OF HUSBAND OR WIFE Herman Kaiser
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. (If no. for war or dates of service) None	17. INFORMANT'S SIGNATURE OR NAME Miss Minnie Kaiser	ADDRESS 102 Fulkerson
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Heart 20 yrs DUE TO (c) Degenerative arteriosclerosis 20 yrs		
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 443X	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) (Min.)	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 **June 19 46** to **6-2-52**, that I last saw the deceased alive on **6-2-52**, and that death occurred at **11:32** m., from the causes and on the date stated above.

23a. SIGNATURE Edward R. Bohner MD	(Degree or title)	23b. ADDRESS Jefferson City	23c. DATE SIGNED 6-4-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE June 1952	24c. NAME OF CEMETERY OR CREMATORY St. Peters	24d. LOCATION (City, town, or county) (State) Jefferson City, Mo.
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DATE REC'D BY LOCAL REG. June 4-1952	REGISTRAR'S SIGNATURE R. P. Davis MD-DR	25. FUNERAL DIRECTOR'S SIGNATURE Laura Sumner	ADDRESS 70 Jefferson
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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 *J. A. Anderson*

Licensed Embalmer No. 3641

P. O. Address *Gene*

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.