

STANDARD CERTIFICATE OF DEATH

State File No. **33105**  
Registrar's No. **8470**

FILED SEP 25 1952

318

1003

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)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6129 Newport Ave		d. STREET ADDRESS (If rural, give location) 6129 Newport Ave	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)				
a. (First) Margaret			19-9-1952				
b. (Middle) Kiel							
c. (Last) Kiel							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-20-1881	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 2 HRS. Mins.
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) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME ?????	13b. MOTHER'S MAIDEN NAME Mertes	14. NAME OF HUSBAND OR WIFE Unknown	14. NAME OF HUSBAND OR WIFE George Kiel
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.	17. INFORMANT'S SIGNATURE OR NAME George Kiel
		16. SOCIAL SECURITY NO.	ADDRESS 6129 Newport Av

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis		
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"/>
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? 331x

22. I hereby certify that I attended the deceased from Jan 3, 1950, to Sept 9, 1952, that I last saw the deceased alive on 9-9-1952 and that death occurred at 1:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE Joseph E. Carney M.D.	(Degree or title)	23b. ADDRESS 700 Olive St	23c. DATE SIGNED 19-9-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-11-1952	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	24d. LOCATION (City, town, or county) (State) Affton Mo No

DATE REC'D BY LOCAL REG. SEP 9 1952	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE W. Biegenheim Bros	ADDRESS 6409 Gravois Ave
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WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD  
GA 0198 9 till 2  
Dr. Carney Frisco Bldg.

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.

Signed.....  
Student Embalmer

Student Embalmer No.....

Signed.....

Licensed Embalmer No.....

P. O. Address.....

*Van M. Szymura*

4343

*St. Louis, 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.