

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7682

State File No. 10

1365

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. 1365
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY JEFFERSON		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HIGH RIDGE MO		
c. LENGTH OF STAY (in this place) 3 hrs		d. STREET ADDRESS (If rural, give location) MERAMEC TOWNSHIP. 0500		
d. FULL NAME OF HOSPITAL OR INSTITUTION INCARNATE WORD HOSE ST LOUIS MO				
3. NAME OF DECEASED (Type or Print) a. (First) KATHRYN b. (Middle) DEARL c. (Last) KAISER		4. DATE OF DEATH (Month) (Day) (Year) JAN. 31-1953		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 1-1898	
9. AGE (In years last birthday) 54		# UNDER 1 YEAR 7	# UNDER 1 YEAR Days 30	# UNDER 1 YEAR Hours 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) CRAWFORD Co MO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13a. FATHER'S NAME CHAS. R. BROOMBAUGH		13b. MOTHER'S MAIDEN NAME Mrs. Queen	14. NAME OF HUSBAND OR WIFE FRANK KAISER	
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. NO	17. INFORMANT'S SIGNATURE OR NAME William Charles Huff	
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) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c) ✓ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ✓		INTERVAL BETWEEN ONSET AND 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) (m.)	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 1/24/53, 19 , to 1/31/53, 19 , that I last saw the deceased alive on _____, 19____, and that death occurred at 10 P m. , from the causes and on the date stated above.				
23a. SIGNATURE T. B. Edwards, M.D.		23b. ADDRESS Cedar Hill, Mo.	23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB-3-1953	24c. NAME OF CEMETERY OR CREMATORY ST MARTINS EVANG. CEM.	24d. LOCATION (City, town, or county) (State) ST MARTINS HIGH RIDGE - MO.	
DATE REC'D BY LOCAL REG. FEB 4 1953	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Howell Springs, 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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Signed.....
Student Embalmer

Licensed Embalmer, No. 4366

P. O. Address _____

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.