

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33528
9398

State File No.

Registrar's No.

FILED OCT 15 1953

318

1003

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| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. 1003 | | State File No. | | Registrar's No. | | | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY _____ | | | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> | | c. LENGTH OF STAY (In this place) <u>19 da</u> | | c. CITY OR TOWN <u>Wilsonville</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Missouri Baptist Hospital</u> | | | | e. STREET ADDRESS (If rural, give location) <u>§1208</u> | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Isabelle D. Kessler</u> | | | a. (First) | | | b. (Middle) | | | c. (Last) | | |
| 4. DATE OF DEATH <u>9 - 29 - 1953</u> | | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | | | 8. DATE OF BIRTH <u>6 - 29 - 1881</u> | | | 9. AGE (In years last birthday) <u>72</u> | | |
| 5. SEX <u>Fem</u> | | | 6. COLOR OR RACE <u>White</u> | | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u> | | |
| 11. BIRTHPLACE (City and State or Foreign Country) <u>Pennsylvania</u> | | | 12. CITIZEN OF WHAT COUNTRY? _____ | | | 13a. FATHER'S NAME <u>John Ditchburn</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Margaret Calhoun</u> | | |
| 14. NAME OF HUSBAND OR WIFE <u>Gustav Kessler</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | 16. SOCIAL SECURITY NO. _____ | | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Herbert Clapp, 8709 Kendale Dr.</u> | | |
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Arteriosclerosis, general</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH _____ | |
| 19a. DATE OF OPERATION _____ | | | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Minute) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>4200</u> | |
| 22. I hereby certify that I attended the deceased from <u>Aug 31</u> , 19 <u>53</u> , to <u>Sept 29</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Sept 29</u> , 19 <u>53</u> , and that death occurred at <u>2:20P</u> m., from the causes and on the date stated above. | | | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Joseph B. Carney M.D.</u> | | | | | | 23b. ADDRESS <u>906 Olive</u> | | | 23c. DATE SIGNED <u>9-30-53</u> | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 24b. DATE <u>10/2/53</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Fairland Cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>Maryville, Illinois</u> | | | | | |
| DATE REC'D BY LOCAL REG. <u>SEP 30 1953</u> | | REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u> | | | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Drehmann-Harral, 1905 Union Blvd.</u> | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Jos. E. Carney
Frisco Bldg.
8AM-2PM

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.....
Signature of Student Embalmer

Signed *Warren A. Carney*.....

Licensed Embalmer No. *353*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.