

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34523

State File No.

FILED OCT 2 - 1953
BIRTH NO. 48704 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 2341

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RICHMOND HEIGHTS</u> c. LENGTH OF STAY (in this place) <u>2 DAYS</u>		c. CITY OR TOWN <u>LEMAY</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>ST. MARY'S HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>708 KARLSRUHE 4000</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>THOMAS</u> b. (Middle) <u>JOHN</u> c. (Last) <u>KIEFER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 30 1953</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	
8. DATE OF BIRTH <u>JUNE 29 1953</u>		9. AGE (In years last birthday) <u>2</u>		10. YRS. <u>2</u> MONTHS <u>2</u> DAYS <u>2</u> HRS. <u>1</u> MIN. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS MO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>JOHN KIEFER</u>		13b. MOTHER'S MAIDEN NAME <u>EILEEN VOGT</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>JOHN KIEFER LEMAY MO</u>	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fulminating pneumonia 2 days</u> ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS <u>Had meningococcal sepsis July 14, 1953 - no apparent connection with death.</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		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 July 6, 1953, to Aug 21, 1953, that I last saw the deceased alive on Aug 21, 1953, and that death occurred at 6:30 P. M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. W. Clumson, M.D.</u>		23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>9/1/53</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>SEPT. 2 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>	
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DATE REC'D BY LOCAL REG. <u>9/1/53</u>		REGISTRAR'S SIGNATURE <u>Herbert S. Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutis 2906 Gravois</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Prof. Budde*.....
Licensed Embalmer No. *398*.....
P. O. Address *H. Lou*.....

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.