

STANDARD CERTIFICATE OF DEATH

State File No. **37321**
Registrar's No. **9977**

FILED NOV 6 - 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Webster Groves 7577	
c. LENGTH OF STAY in this place 2 Days		d. STREET ADDRESS (If rural, give location) 681 Clark Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) OSCAR b. (Middle) JOHN c. (Last) KAISER			4. DATE OF DEATH (Month) (Day) (Year) Oct. 18, 1953
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 4-28-1893
9. AGE (In years last birthday) 60		10. MONTHS 60	11. DAYS 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man		10b. KIND OF BUSINESS OR INDUSTRY Retail Hdwe.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME George Kaiser		13b. MOTHER'S MAIDEN NAME Anna M Dwork	14. NAME OF HUSBAND OR WIFE None
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. 497-16-7670	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Anna M Kaiser 681 Clark Ave.
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) Acute Asymptomatic Bronchitis (infectious) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute pulmonary edema DUE TO (c) Chronic Nephritis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myocarditis (Hyperlipemic heart disease)?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		592x	
22. I hereby certify that I attended the deceased from Oct 12, 1953 , to Oct 18, 1953 , that I last saw the deceased alive on Oct 18, 1953 , and that death occurred at about 5 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Hector Reese M.D.		23b. ADDRESS 170 E Lockwood Webster Groves	
23c. DATE SIGNED 10/19/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-20-1953	
24c. NAME OF CEMETERY OR CREMATORY St. Peters		24d. LOCATION (City, town, or township) (State) Kirkwood Mo.	
DATE RECD. BY LOCAL REG. OCT 20 1953		REGISTRAR'S SIGNATURE J. Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE J. Carl Smith		ADDRESS 1 Home Webster Groves Mo.	

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

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(Licensed Embalmer's Statement on Reverse Side)

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 Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Roberts Grove TN

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.