

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6397**  
Registrar's No. **1800**

FILED MAR 8 1954 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)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b>		a. STATE <b>Mo</b>	b. COUNTY <b>2149</b>
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		d. STREET ADDRESS <b>6268 Delor</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <b>John</b>	b. (Middle) <b>M</b>	c. (Last) <b>Kalisch</b>	<b>Feb 23, 1954</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Nov 26, 1875</b>	9. AGE (In years last birthday) <b>78</b>	<input type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Florist</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St Louis Mo</b>	
13a. FATHER'S NAME <b>William Kalisch</b>		13b. MOTHER'S MAIDEN NAME <b>Theresia Schneider</b>		14. NAME OF HUSBAND OR WIFE <b>Josephine M Kalisch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Josephine M Kalisch</b>	
				ADDRESS <b>6268 Delor</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Adenocarcinoma of transverse colon</b>			<b>unknown</b>
		ANTECEDENT CAUSES			
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b)			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS			
		Conditions contributing to the death but not related to the disease or condition causing death. <b>Atherosclerotic Heart Disease</b>			
19a. DATE OF OPERATION <b>1-27-54</b>		19b. MAJOR FINDINGS OF OPERATION <b>Adenocarcinoma of transverse colon with metastasis</b>			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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <b>153 X</b>	
22. I hereby certify that I attended the deceased from <b>Dec 17, 1953</b> , to <b>Feb 23, 1954</b> , that I last saw the deceased alive on <b>Feb 22, 1954</b> , and that death occurred at <b>6:40 Am.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>Jesse Younger, M.D.</b>			23b. ADDRESS <b>634 N. Grand</b>		23c. DATE SIGNED <b>2-24-54</b>
24a. BURIAL, CREMATION, REMOVAL <b>Removal</b>		24b. DATE <b>2/26/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cemetery</b>	
				24d. LOCATION (City, town, or county) (State) <b>St Louis County Mo.</b>	
DATE REC'D BY LOCAL REG. <b>FEB 25 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>L Ziegenhein &amp; Sons</b>	
				ADDRESS <b>7027 Gravois</b>	

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 \_\_\_\_\_

*Donald E. Berg*  
working under my personal supervision

Student Embalmer No. *4863*

Student *Donald E. Berg*  
Student Embalmer

Signed *B. J. K. K. K.*

Licensed Embalmer No. *3877*

P. O. Address *7027 Grand*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.