

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31929

State File No. _____
Registrar's No. 7895

BIRTH NO. 65316-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

FILED SEP 22 1954

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

1. PLACE OF DEATH a. COUNTY _____		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) <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Lemay #870</u>	
c. LENGTH OF STAY (In this place) <u>17 days</u>		d. STREET ADDRESS (If rural, give location) <u>407 E Arlic</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Evangelical Deaconess Hosp.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Cindy</u> b. (Middle) <u>Lee</u> c. (Last) <u>Kaiser</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>8-26-54</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Intact</u>	8. DATE OF BIRTH <u>Aug. 9, 1954</u>
9. AGE (In years last birthday) <u>17</u>	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 1 MIN. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>Harold Keith Kaiser</u>		13b. MOTHER'S MAIDEN NAME <u>Geraldine Grouthou</u>	
14. NAME OF HUSBAND OR WIFE —			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. —	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. H. Kaiser 407 E Arlic Lemay Mo</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>MICROGYRIA of Cerebrum</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congenital defect</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>BRONCHOPNEUMONIA</u>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>7531</u>			
22. I hereby certify that I attended the deceased from <u>Aug 9, 1954</u> to <u>Aug 26, 1954</u> , that I last saw the deceased alive on <u>Aug 25, 1954</u> , and that death occurred at <u>7:00 a.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>William L. Jurek Jr. PATHOLOGIST</u>		23b. ADDRESS <u>634 N. GRAND AVE</u>	
23c. DATE SIGNED <u>8-26-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Aug 26</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Patton, Mo.</u>		24d. LOCATION (City, town, or county) (State) <u>Patton, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>AUG 26 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Baker Funeral Home</u>		ADDRESS <u>Lutesville, Mo.</u>	

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

Not Embalmed
Signed *Arthur W. Sulistay* _____

Licensed Embalmer No. *3872* _____

P. O. Address *Imperial Mo.* _____

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. .