

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31935
8273

State File No.

Registrar's No.

FILED SEP 21 1954

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1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No.	
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY _____				Registrar's No.	
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>May 8, 1947</u>		c. CITY OR TOWN <u>St. Louis.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>St. Louis Chronic Hospital</u>		19. STREET ADDRESS <u>5800 Arsenal St.</u>		20. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>A.</u> c. (Last) <u>Kessler.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>September 4, 1954</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>May 8th, 1872</u>		9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drugstore</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Joseph Kessler.</u>		13b. MOTHER'S MAIDEN NAME <u>Magdalene Tritch.</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE, OR NAME AND ADDRESS <u>Mr. Charles N. Welsh, Jr., 8th & Locust c/o Mercantile Trust Co.</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, asthenia, 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 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.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? <u>4200</u>				22. I hereby certify that I attended the deceased from <u>May 8, 1947</u> , to <u>September 19, 1954</u> I last saw the deceased alive on <u>Sept. 4, 1954</u> , and that death occurred at <u>12, 20AM</u> from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>Palmer Duane Bowditch M.D.</u>		23b. ADDRESS <u>5800 Arsenal St.</u>		23c. DATE SIGNED <u>9-4-54</u>			
24a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal-Rail</u>		24b. DATE <u>9/8/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Morgan Ohio Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Morgan, Ohio</u>	
DATE REC'D BY LOCAL REG. <u>SEP 8 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>CALVIN F. FEUZ, 4828 Natural Bridge Blvd., FUNERAL HOME, INC., St. Louis, 15, Mo.</u>			

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 *John A. Melina*.....
Licensed Embalmer No. *418*.....

P. O. Address *St. Louis*.....

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.