

STANDARD CERTIFICATE OF DEATH

State File No. **20556**
1873

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **1873**

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived? If institution: residence before admission). a. STATE Mo. b. COUNTY _____	
b. CITY OR TOWN Koch		c. CITY OR TOWN St Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 61 months		e. STREET ADDRESS (If rural, give location) 5041 Claxton Ave	
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Lucille b. (Middle) Mildred c. (Last) Kayser			4. DATE OF DEATH (Month) (Day) (Year) Aug. 10th 1955		
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5. SEX F	6. COLOR OR RACE W	7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 11-15-1915	9. AGE (In years last birthday) 39	IF UNDER 1 YEAR Months 9 Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) JENNINGS MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Fred Kayser	13b. MOTHER'S MAIDEN NAME Alvena McCabe	14. NAME OF HUSBAND OR WIFE None
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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. 491-12-9335	17. INFORMANT'S SIGNATURE OR NAME Ferdinand Kayser - Son, Mo.	ADDRESS _____
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 5 years
	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.		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 002X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 7th, 1955**, to **Aug 10th, 1955**, that I last saw the deceased alive on **Aug 10, 1955**, and that death occurred at **10 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE Bernard Friedman	(Degree or title) M. D. O.	23b. ADDRESS Robert Koch Hospital Koch Mo.	23c. DATE SIGNED 8-10-55
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24a. DATE 8-13-1955	24b. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24c. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. 8/11/55	REGISTRAR'S SIGNATURE Herbert R. Donke MD	25. FUNERAL DIRECTOR'S SIGNATURE William Woodson	ADDRESS 2504 Woodson Rd - Overland, Mo.
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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 *David C. Gibson*

Licensed Embalmer No. *345*
P. O. Address *Overland*

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.