

FILED AUG 24 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **28569**  
**6668**  
Registrar's No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 <b>Mo.</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>In route to Home Phillip Hast</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	
3. NAME OF DECEASED (Type or Print) <b>Kiser</b>		d. STREET ADDRESS (If rural, give location) <b>27509 S. 23rd St</b>	
a. (First)		b. (Middle)	
4. DATE OF DEATH (Month) (Day) (Year) <b>July 13, 1956</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	
8. DATE OF BIRTH <b>Sept 1900</b>		9. AGE (In years last birthday) Months Days <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yardman &amp; Gardener</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
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) <b>No</b>	
16. SOCIAL SECURITY NO. <b>499-20-8131</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Meriwether, 597 S. 23rd St</b>	
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) <b>Subarachnoid Hemorrhage</b>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>of the Brain.</b> DUE TO (c) <b>(non-traumatic)</b>	
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 <b>330 x</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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>5:20 P.</b> m., from the causes and on the date stated above.	
23a. SIGNATURE <b>James M. Keely</b>		23b. ADDRESS <b>1300 Clark</b>	
23c. DATE SIGNED <b>7-17-56</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
24b. DATE <b>7/19/1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>		24e. DATE REC'D BY LOCAL REG. <b>JUL 17 1956</b>	
REGISTRAR'S SIGNATURE <b>J. Earl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. W. Bruce</b>	
ADDRESS <b>4469 Washington Blvd. St. Louis 8, Mo.</b>		S.P. (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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed *Frederick P. Stark*

Licensed Embalmer No. *4599*

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