

DIED JUL 1 1957

THE DIVISION OF HEALTH, OF MISSOURI  
STANDARD CERTIFICATE OF DEATH57 0 2 3 1 5 4  
State File No.

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>1430</u>	
1. PLACE OF DEATH a. COUNTY <u>Lemay, St. Louis,</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Ste Genevieve</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lemay</u>		c. LENGTH OF STAY (in this place) <u>2 yrs</u>		c. CITY OR TOWN <u>Ste Genevieve</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 (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Mount St. Rose Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>227 N. Main St. Ste Genevieve</u> <u>09510</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Agnes</u>		b. (Middle) <u>L.</u>		c. (Last) <u>Kiefer</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6</u> <u>4</u> <u>57</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. <del>MARRIED</del> NEVER MARRIED <u>Never Married</u>		8. DATE OF BIRTH <u>Oct. 27, 1900</u>	
9. AGE (In years last birthday) <u>56</u>		IF UNDER 1 YEAR Months <u>56</u> Days		IF UNDER 24 HRS. Hours <u>56</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses Aid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Ste Genevieve, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Peter K Kiefer</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Bader</u>		14. NAME OF HUSBAND OR WIFE <u>Nil.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> <u>Nil.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Josph Abb, Ste Genevieve, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u> <u>Septicemia</u> ANTECEDENT CAUSES <u>Uremia</u> DUE TO (b) <u>Chronic Glomerulonephritis</u> DUE TO (c) <u>Chronic Glomerulonephritis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 yrs</u> <u>years.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <u>592X</u> 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?			
22. I hereby certify that I attended the deceased from <u>2-1</u> , 19 <u>55</u> , to <u>6/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/3</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Mrs. M. O. Mohr M.D.</u>				23b. ADDRESS <u>607 N. Grand</u>		23c. DATE SIGNED <u>6/6/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>6-5-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>		24d. LOCATION (City, town, or county) (State) <u>Ste Genevieve, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>6-6-57</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donk</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington,</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

APR 4 1958

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.....  
Licensed Embalmer No. 4116  
P. O. Address

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.