

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045269

STATE FILE NUMBER

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 293

FILED DEC 29 1958

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN St. Charles		c. CITY OR TOWN Hazelwood	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp.		d. STREET ADDRESS (If outside, give location) 412 Fee Fee Hills Dr.	

3. NAME OF DECEASED (Type or print) First Middle Last Nellie G. Kaiser			4. DATE OF DEATH Month Day Year Dec. 23, 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1871		9. AGE (In years <small>at birth</small>) 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and state or country) Springfield Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Michael Malony		13b. MOTHER'S MAIDEN NAME Ellen Mulqueene	
14. NAME OF HUSBAND OR WIFE Jacob C. Kaiser		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Jacob C. Kaiser		Address 412 Fee Fee Hills Dr.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post operative shock		INTERVAL BETWEEN ONSET AND DEATH 15 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Open reduction of fracture right femur DUE TO (c) (Surgeon B.L. Neubeiser MD St. Charles Mo)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) General Debility of old age 9040		

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Fell in snow at home	
20c. TIME OF INJURY Hour 7 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> Month, Day, Year Dec 19 1958		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION Roberts 400	COUNTY St. Louis Co	STATE Mo
21. I attended the deceased from Feb 5 1957 , to Dec 23 1958 and last saw her/him alive on Dec 22 1958 Death occurred at 3:30 pm on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE Walter E. Gray MD	(Degree or title) MD	22b. ADDRESS 8711 St. Charles Road St. Louis Mo	22c. DATE SIGNED Dec 23 1958
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/26/58	23c. NAME OF CEMETERY OR CREMATORY Valvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Mo.

24. FUNERAL DIRECTOR Collier Mortuary, St. Ann, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. Dec. 23-58	26. REGISTRAR'S SIGNATURE Wesley Wilson
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Sheldon Collier.....

Licensed Embalmer No. 3382

P. O. Address St. Ann. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.