

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015219

STATE FILE NUMBER
2 3202

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST. LOUIS</i>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Mo. BAPTIST Hosp.</i>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <i>2075 WITHNELL</i>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <i>MERLE KAISER</i>			4. DATE OF DEATH Month <i>MAR.</i> Day <i>29</i> Year <i>1959</i>		
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5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>APR. 27 1894</i>	9. AGE (In years last birthday) <i>64</i>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 MRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SHIPPING CLERK</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>ST. LOUIS CORDAGE</i>	11. BIRTHPLACE (City and state or country) <i>ILLINOIS 1</i>	12. CITIZEN OF WHAT COUNTRY? <i>U-S-A</i>
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13a. FATHER'S NAME <i>JESS KAISER</i>	13b. MOTHER'S MAIDEN NAME <i>NELLIE THORN</i>	14. NAME OF HUSBAND OR WIFE <i>ETHEL KAISER</i>
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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) <i>No</i>	16. SOCIAL SECURITY NO. —	17. INFORMANT <i>ETHEL KAISER</i> Address: <i>2075 WITHNELL</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial failure result of epicardial metastases</i>		INTERVAL BETWEEN ONSET AND DEATH <i>16 mo.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Bronchogenic Carcinoma Rt lung</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>metastases Rt suprarenal gland.</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input 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.) <i>162.1</i>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <i>Feb. 22 1959</i> to <i>March 29th 1959</i> and last saw him alive on <i>Mar. 29, 1959</i> Death occurred at <i>8 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Dominic J. Verdo M.D.</i>	22b. ADDRESS <i>4500 0 hwy.</i>	22c. DATE SIGNED <i>3-31-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>APR. 1 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>SUNSET BURIAL PK</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo.</i>
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24. FUNERAL DIRECTOR <i>Thomas Kutes 1906 Gravis</i>	25. DATE RECD. BY LOCAL REG. <i>MAR 31 '59</i>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

300
1-57
9
43
0

MEDICAL CERTIFICATION

10
64 / -51

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 Samuel C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 Travis

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.