

DECEASED

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042851

FILED VS DEC 3 1959

Registration District No. 17

Primary Registration District No. 547

Registrar's No. 3066

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights		Length of stay in 1b 1 Mo.		c. CITY OR TOWN Webster Groves		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 750 E. Big Bend		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND A. KAISER				4. DATE OF DEATH Month Day Year 11-18-1959			
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-26-1902	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY Pullman Co.		11. BIRTHPLACE (City and state or country) National Iowa		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Wm. F. Kaiser			13b. MOTHER'S MAIDEN NAME Augusta Groth		14. NAME OF HUSBAND OR WIFE Mildred V. Kaiser		
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. 489-22-3185	17. INFORMANT Address Mrs. R.A. Kaiser 750 E. Big Bend				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cryptococcal Encephalomeningitis						INTERVAL BETWEEN ONSET AND DEATH 8 weeks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Cryptococcus neoformans					
		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <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
21. I attended the deceased from 10-25-59 to 11-18-59 and last saw her/him alive on 11-15-59 Death occurred at 12:08 PM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) John W. Berry, MD				22b. ADDRESS 950 Francis Place Crayton 5-Mo		22c. DATE SIGNED 11-19-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-19-1959	23c. NAME OF CEMETERY OR CREMATORY Monona Cemetery		23d. LOCATION (City, town, or county) (State) Monona Iowa.			
24. FUNERAL DIRECTOR ADDRESS Parker-Aldrich Webster Groves Mo.				25. DATE RECD. BY LOCAL REG. 11-19-59	25. REGISTRAR'S SIGNATURE John C. Murphy MD		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *Leslie Halch* _____

Licensed Embalmer No. *4395*

P. O. Address *Wabster Gno*

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.