

FEDERAL BUREAU OF INVESTIGATION  
 U.S. DEPARTMENT OF JUSTICE  
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**MURKIN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 0 4 6 2 2 8

FILED VS DEC 21 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3263

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirkwood</b>		Length of stay in 1b <b>2 Weeks</b>	c. CITY OR TOWN <b>Hazelwood</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Josephs Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>416 Fee Fee Hills Dr.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle <b>C.</b> Last <b>Kaiser</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>5,</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/19/1870</b>	9. AGE (last birthday) <b>89</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grading</b>	11. BIRTHPLACE (City and state or country) <b>Denmark</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>

13a. FATHER'S NAME <b>unk.</b>		13b. MOTHER'S MAIDEN NAME <b>unk.</b>		14. NAME OF HUSBAND OR WIFE <b>The Late Nellie Kaiser</b>	
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>487 38 2465A</b>	17. INFORMANT Address <b>Eileen Shuey 416 Fee Fee Hills Dr.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Confluent Bronchopneumonia, bilat. 2 Weeks</b> DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Vascular degeneration of Prostate.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Weeks</b>
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 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.) <b>Gas. fell out of wheelchair. Has been in constant use since.</b>	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 20 Nov. to 5 Dec. and last saw her/him alive on 4 Dec. 59  
 Death occurred at 58 December 59 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <b>Jacques P. Shuey, M.D.</b>		22b. ADDRESS <b>6500 Chippewa</b>	22c. DATE SIGNED
23a. GENERAL BURIAL	23b. DATE <b>11/9/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>

24. FUNERAL DIRECTOR <b>Collier Mortuary, St. Ann, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-7-59</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6500 E. ...  
7-5 ... Room 215  
Dr. Schul...

**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. 338

P. O. Address St. Ann

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.