

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-012822**

**FILED VS MAR 17 1960**

Primary Registration District No. \_\_\_\_\_

Registrar No. **2 2726**

STATE FILE NUMBER

INDEXED

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>	Length of stay in 1b <b>31 yrs</b>	c. CITY OR TOWN <b>St. Louis</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>3251 Hawthorn Blvd.</b>		d. STREET ADDRESS (If outside, give location) <b>3251 Hawthorn Blvd.</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Elise</b> Middle <b>Spross</b> Last <b>Kiesel</b>			4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1960</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/24/1874</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Germany</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>August Spross</b>		13b. MOTHER'S MAIDEN NAME <b>Zinameister</b>		14. NAME OF HUSBAND OR WIFE <b>G. F. Kiesel Sr.</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>No</b>	17. INFORMANT <b>G. F. Kiesel Sr. 3251 Hawthorn Blvd.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>CEREBRAL THROMBOSIS, OLD P RECENT</b>	<b>3 MONTHS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b>	<b>YEARS</b>
	DUE TO (c) <b>332 L</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>MULTIPLE DECATIBUS</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 **MARCH 1955** to **6 MARCH 1960** and last saw her him alive on **6 MARCH, 1960**  
Death occurred at **2:30P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Roberta M. Mayer MD</b> (Degree or title)	22b. ADDRESS <b>950 FRANCIS PLACE CLAYTON, 5 Mo</b>	22c. DATE SIGNED <b>3/8/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3/9/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>
23d. LOCATION (City, town, or county) <b>St. Louis County, Mo.</b>		

24. FUNERAL DIRECTOR ADDRESS <b>Hoffmeister Colonial Mortuary 6464 Chippewa St. St. Louis, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 8 1960</b>	26. REGISTRAR'S SIGNATURE <b>Rand Smith M.D.</b>
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BY AFFIDAVIT OF

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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bill C. Brannon

Licensed Embalmer No. 4767

P. O. Address St. Louis

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.