

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b		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>BARNES HOSPITAL</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3108 Minnesota</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First      Middle      Last <b>HENRY      NMN      KIESEL</b>			4. DATE OF DEATH Month      Day      Year <b>MAY      11      1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>8-27-1888</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months      Days	IF UNDER 24 HR Hours      Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired auto salesman</b>			10b. KIND OF BUSINESS OR INDUSTRY		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>George Kiesel</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Frieda Kiesel</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>515-05-2330</b>		17. INFORMANT Address <b>Frieda Kiesel 3108 Minnesota</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>RUPTURED ANTERIOR VENOUS MALFORMATION OF LEFT PARIETAL LOBE, CONGENITAL</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.      DUE TO (b) _____ DUE TO (c) _____ <b>954.7</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>BLEEDING GASTRIC ULCER</b> 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      Month, Day, Year a.m.      p.m.							
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 <b>JAN. 31, 1941</b> to <b>MAY 11, 1960</b> and last saw her/him alive on <b>MAY 11, 1960</b> Death occurred at <b>12:00 NOON</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>C. O. Vermillion, M.D.</i> (Degree or title)			22b. ADDRESS <b>BARNES HOSPITAL</b>			22c. DATE SIGNED <b>5/12/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>May 14 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>St Louis      Mo</b>		
24. EMPEROR DIRECTOR <b>Thomas Katis</b> ADDRESS <b>2906 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 13 1960</b>		26. REGISTRAR'S SIGNATURE <i>Roald Snijth, M.D.</i>			

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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed Eleana Provin

Licensed Embalmer No. 340

P. O. Address 2906 gro

**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.