

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033784

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8289

FILED AUG 22 1963

DO NOT WRITE ON THIS STUB      AMENDED

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Length of stay in 1b <u>23</u> years		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____  c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1901 E. Warne Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1901 E. Warne Avenue</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1901 E. Warne Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print)      First      Middle      Last <u>Emilie (Emily) Kaiser</u>			<b>4. DATE OF DEATH</b> Month      Day      Year <u>August 13, 1963</u>				
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3-3-1868</u>	<b>9. AGE (last birthday)</b> <u>95</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ Hours _____ Min. _____	<b>IF UNDER 24 HR</b> Months _____ Days _____ Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>at home</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>New Athens, Illinois</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>Sackwitz</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>unknown</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>deceased</u>		

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of serv) <u>no</u>	<b>16. SOCIAL SECURITY NO.</b> _____	<b>17. INFORMANT</b> Address <u>Mrs. Frieda Rupp, 1901a E. Warne Ave</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr Myocarditis</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronular Fibillation</u> DUE TO (c) <u>Senility 433.1</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____	
<b>20c. TIME OF INJURY</b> Hour      Month, Day, Year _____      a.m.      _____			

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY      STATE _____
<b>21. I attended the deceased from</b> <u>1960</u> to <u>8/13/63</u> and last saw her/him alive on <u>8/13/63</u> Death occurred at <u>6:30</u> a.m. on the date stated above, and, to the best of my knowledge, from the causes stated.		

<b>22a. SIGNATURE</b> (Degree or title) <u>Math Hermann</u>	<b>22b. ADDRESS</b> <u>6917 W Pleasant</u>	<b>22c. DATE SIGNED</b> <u>8/13/63</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>	<b>23b. DATE</b> <u>8-15-63</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Matthew Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Louis, Missouri.</u>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Math Hermann &amp; Son, Inc. 2161 E. Fair Ave.</u> <u>St. Louis 7, Missouri.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>AUG 15 1963</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Coal Smith, M.D.</u>
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STATE OF MISSISSIPPI

**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 Welford G. Bursley

Licensed Embalmer No. 4202

P. O. Address St Johns Rd

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.