

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-004008

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 609

AMENDED

FILED JAN 19 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
1-23-60 to 1-12-62		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Masonic Home of Missouri</u>		d. STREET ADDRESS (If outside, give location) <u>5351 Delmar Blvd.</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marie H Kaiser</u>			4. DATE OF DEATH Month Day Year <u>January 12 1962</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-1874</u>
9. AGE (last birthday) <u>87</u>		IF UNDER 1 YEAR Months Days <u>14</u>	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Joseph W. Baeppler</u>	
13b. MOTHER'S MAIDEN NAME <u>Sophie Dauer</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased - ROBERT KAISER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Masonic Home of Mo - 5351 Delmar Blvd.</u> <u>Earl Stein</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u>			<u>unknown</u>
DUE TO (c) <u>4201</u>			
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
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 <u>1-23-1960</u> to <u>1-12-62</u> and last saw her <u>on</u> alive on <u>1-12-62</u> Death occurred at <u>2:15</u> p m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Harold E. Walters M.D.</u>		22b. ADDRESS <u>3720 Washington St. Louis</u>	22c. DATE SIGNED <u>1-12-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Jan. 15, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri.</u>
24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons 7233 Delmar Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 15 1962</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 2 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

See from 1:00 p.m.
See Monday City
Lawson

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 *Clarence A. Murray*

Licensed Embalmer No. *4011*

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.