# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

Do not use this space.

10150

791

1003

File No. .....

Registered No. 2733

**1. PLACE OF DEATH**

County .....

Township .....

City St Louis (No. 3918 Filmore St. ..... Ward)

Registration District No. .....

Primary Registration District No. .....

**2. FULL NAME** Katherine Nicolay

(a) Residence. No. 3918 Filmore St., 1 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Rudolph Nicolay

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 11. 1860

7. AGE: Years 67 | Months 2 | Days 7 | If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St Louis Mo

PARENTS

10. NAME OF FATHER: John Kutchenrueter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

12. MAIDEN NAME OF MOTHER: Elizabeth Widinger

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT: Emma Nicolay
(Address) 3918 Filmore St

15. FILED ..... 19 27 Max C Starkloff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mar 18 1927

17. I HEREBY CERTIFY, That I attended deceased from Mar 18th, 1927, to Mar 18th, 1927, that I last saw her alive on Mar 18th, 1927, and that death occurred, on the date stated above, at 9.50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia

1 day (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY): As above

(duration) ..... yrs. ..... mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED? 1000

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Stethoscope & Bedroy

(Signed) [signature], M. D

3/19, 1927 (Address) 6104 [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Olive

DATE OF BURIAL: Mar 21 1927

20. UNDERTAKER: Wacker-Helderle

ADDRESS: 2331 S Bdwy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.