

8321 N 13th Way  
Helwig

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

Do not use this space.

16153

1. PLACE OF DEATH

County St. Louis Registration District No. 784  
Township St. Ferdinand Primary Registration District No. 6030  
City Spanish Lake, Mo St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Rose Kuhs

(a) Residence No. 8538 Church Rd. St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
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 Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF C. L. Kuhs

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 10 1917

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
40 yrs 1 13

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

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

10. NAME OF FATHER Ernst Oberbeck

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis  
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Wilhelmina Schweigher

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis  
(STATE OR COUNTRY) Mo

14. INFORMANT Edward P. Kuhs  
(Address) 8538 Church Rd.

15. FILED May 29 1927 REGISTRAR O. A. Schuck

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 22 1927

17. I HEREBY CERTIFY That I attended deceased from June 12 1925 to May 23 1927 and that I last saw her alive on May 22 1927, and that death occurred, on the date stated above, at 6 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Glionia Brain  
53C  
87H (duration) 2 yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) Cerebral Hemorrhage - apoplexy  
(duration) \_\_\_\_\_ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF July 25/27

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physician findings  
(Signed) J. P. Heckerling, M. D.  
(Address) 8321 N 13th Parkway

\*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 Bellefontaine Cemetery DATE OF BURIAL 5/25/27

20. UNDERTAKER AKON & Co 2707 N Grand

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Louis Registration District No. 784 File No. \_\_\_\_\_  
 Township St. Ferdinand Primary Registration District No. 6080 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Rose Kuhe  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 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 D 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (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) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

**14.**

INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

**15.**

FILED 7-15-27 O. N. Schuder  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 23 1927

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, (that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral Hemorrhage  
Maligant  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) Cerebral Hemorrhage  
Epilepsy (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address) \_\_\_\_\_

\*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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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