

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

Do not use this space.

28661

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **8197**

City **St. Louis Mo** (No. **Mo. Baptist Hospital**) St. Ward)

2. FULL NAME Eugene F Kohl

(a) Residence. No. **1168 N. Taylor St.** **19** Ward.

(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 **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 7 1877**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
50 1 5

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

9. BIRTHPLACE (CITY OR TOWN) **Pacific Missouri**
(STATE OR COUNTRY)

10. NAME OF FATHER **Charles Kohl**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Pacific Missouri**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Elizabeth Johnson**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Missouri**
(STATE OR COUNTRY)

14. INFORMANT **Mrs. Laura A. Waller**
(Address) **1108 N. Taylor Ave**

15. **SEP 15 1927** **Max C. Starbuck**
FILED 19. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **9-13-1927**

17. I HEREBY CERTIFY, That I attended deceased from **August 1, 1927**, to **Sept. 13, 1927** that I last saw him alive on **Sept. 13, 1927**, and that death occurred, on the date stated above, at **11 P. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis (chronic)
38 34 930
(duration) **1** yrs. mos. ds.

CONTRIBUTORY **Tues**
(SECONDARY) (duration) **1 P.** yrs. mos. ds.

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

Did an operation precede death? **No.** DATE OF

WAS THERE AN AUTOPSY? **No.**

WHAT TEST CONFIRMED DIAGNOSIS? **Autopsy & clinical findings**
(Signed) **Charles A. Fox**, M. D.
, 19 (Address) **6123 Eastman Ave**

*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 **Memorial Park** DATE OF BURIAL **Sept 16 1927**

20. UNDERTAKER **Kreephausen and Co** ADDRESS **410 4 Manchester**

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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