

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

Do not use this space.

32248

1. PLACE OF DEATH

County.....
Township.....
City.....*St. Louis* (No. *1433* *Denrose St.*)

Registration District No. **791**
Primary Registration District No. **1008**

File No.
Registered No. **9638** St. Ward)

2. FULL NAME

(a) Residence. No. *1433 Denrose St.* St. *9* 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 (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec. 1, 1884*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>42</i>	<i>10</i>	<i>26</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Ret. Home*
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Sandallia, Ills.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Jacob Koch*

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

12. MAIDEN NAME OF MOTHER *Martha Brown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Hagerstown, Ills.*
(STATE OR COUNTRY)

14. INFORMANT *Robert Kolbe*
(Address) *1433 Denrose St.*

15. FILED *OCT 25 1927* *Max C. Starckoff* REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 27 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 1* 1927, to *Oct 27* 1927 that I last saw him alive on *Oct 27* 5:40 p.m. 1927, and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

Open Tuberculosis Kofliko
Chronic
131
132B (duration) yrs. *2* mos. ds.

CONTRIBUTORY *Uremia*
(SECONDARY) (duration) yrs. mos. *10* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Cliff Hunter*, M. D.
10/25, 1927 (Address) *2405 S 14th*

*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

New Bethlehem *Oct 30 1927*

20. UNDERTAKER

ADDRESS

Math. Hermann & Son *4103 W. West*
St. Louisant, Mo.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

