

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

Do not use this space.

35621

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **817 Filmore St**)

File No. ....

Registered No. **10397**

St. .... Ward)

**2. FULL NAME** **Elizabeth Kohn**

(a) Residence. No. **817 Filmore 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** (write the word)

**Widow**

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

**John Kohn**

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

**Don't know**

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

**abt 66**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.

**Housework**

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

**at home**

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

**Germany**

**10. NAME OF FATHER**

**Peter Rembold**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**Germany**

**12. MAIDEN NAME OF MOTHER**

**Margaret West**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**Germany**

**14. INFORMANT**

(Address)

**Francis Kohn  
817 Filmore St**

**15. FILED**

19

**Max C. Starker  
REGISTRAR**

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** **Oct 22 1929**

**17.**

I HEREBY CERTIFY, That I attended deceased from.....

**October 18, 1929, to October 22, 1929**

that I last saw her alive on **October 21st, 1929**, and that death occurred, on the date stated above, at **10:30 a.m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Chronic interstitial Nephritis  
131  
10.6.39 9 a**

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

CONTRIBUTORY (SECONDARY)

**Chronic Bronchitis**

**non Tubercular** (duration) ..... 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

**Chemical Exam.**

(Signed) **R. P. Ronghman** M. D.

**Oct 22, 1929 (Address) 3567 Thomas St**

\*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**

**Calvary Cem**

**Oct 25 1929**

**20. UNDERTAKER**

**ADDRESS**

**Thos J. ...**

**1519 S Grand**

AT 25.—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.

