MAY 25 1934

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

Do not use this space.

13984

1. PLACE OF DEATH
County St. Charles
Township St. Charles
City St. Charles (No. 809 Washington St. Ward)

Registration District No. 757
Primary Registration District No. 3036

File No.
Registered No. 58

2. FULL NAME Jacquelin Jean Kohlenhoefer
(a) Residence, No. 809 Washington 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. 4 mos. 1 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): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 13, 1933

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	—	4	1	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Charles, Mo

FATHER
13. NAME Glenwood Kohlenhoefer
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Charles, Mo

MOTHER
15. MAIDEN NAME Wilma Nesslage
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Charles, Mo

17. INFORMANT (ADDRESS) Glenwood Kohlenhoefer 809 Washington St. Charles, Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Peters Cem. DATE April 16, 1934

19. UNDERTAKER (ADDRESS) Steinbrinker's St. Charles, Mo

20. FILED 4/16 1934 Florence G. Hess Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 14, 1934

22. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1933, to April 14, 1933
I last saw h. alive on April 14, 1934. Death is said to have occurred on the date stated above, at 1:15 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Meningitis (Staph. Aureus)	April 7-1934
Other contributory causes of importance: Pelvic Abscess (g. c). Oophorectomy Bilateral	Jan 5-1934

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) B. Gerst Howard, M. D.
(Address) 200 Clayton St. Charles, Mo

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Charles 13984

58

r Sir:

It is essential that death certificates be complete in every particular in or- that proper classification may be made. You are therefore requested to make ry effort to obtain the following information, indicated by check marks, lacking m the death certificate.

e: Jacqueline Jean Kahlenhaefer

died at _____ on Apr 14 - 1934

dence: No. _____ St. _____

(If nonresident, city or town)

gth of residence in city or where death occurred: Years _____ Months _____ Days _____

F Color or race W Single, ~~married, widowed or divorced~~: _____

of birth _____ Age: Years _____ Months 4 Days 1

pation: (a) Trade, profession, or ticular kind of work done, as spinner, yer, bookkeeper, etc.

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

deceased last worked at this occupation: Month _____ Year _____

hplace (State or country) _____

hplace of father (State or country) Epidemic

hplace of mother (State or country) _____

cipal cause of death: Meningitis (Streptococcus) (Specify)

(S.C.) Pyelonephritis - Bilateral

ee abscess

r contributory causes of importance _____

of operation _____ Date of _____

test confirmed diagnosis? _____ Was there an autopsy? _____

eath was due to external causes (violence) fill in also the following:

dent, suicide, or homicide? _____ Date of injury _____, 19 _____

e did injury occur? _____

(Specify city or town, county and State)

ify whether injury occurred in industry, in home, or in public place.

er of injury _____

re of injury _____

disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar Clarence G. Nessler

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh M.D.

Special Agent.

Reg. Dist. No. 757

Primary Reg. Dist. No. 2036

S-13984