

WRITE PLAINLY, WITH UNFADING INK

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.

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

Do not use this space.

MAY 25 1934

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis Mo.** (No. **42032**) **Swan Ave.** St. _____ Ward _____

File No. **14878**
Registered No. **4073**

2. FULL NAME **Charles Frederick Kohler**

(a) Residence, No. **42032 Swan** St. **18** Ward. _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 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 **Female Kohler**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **April 28 - 1905**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
28. 11. 24.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Shoe worker**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **Boyd + Meloch**

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) **Arconada Co Mo**

FATHER 13. NAME **Thomas Kohler**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Switzerland**

MOTHER 15. MAIDEN NAME **Timerva Conoll**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Bland Mo**

17. INFORMANT **Female Kohler**
(ADDRESS) **42032 Swan Ave**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **Immorial Park** DATE **Apr 24 - 1934**

19. UNDERTAKER **Edith E. Ambrose**
(ADDRESS) **4334 Manhattan or**

20. FILED **HTL 40 1007**
J. F. Bredecke
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Apr 22 - 1934**

22. I HEREBY CERTIFY, That I attended deceased from **April 21st 1934, to April 22nd 1934**

I last saw him alive on **April 21st 1934**. Death is said

to have occurred on the date stated above, at **4:10 a. m.**

The principal cause of death and related causes of importance were as follows:

Hemorrhage in Brain Resulting in right paralysis

Date of onset **4-21**

Other contributory causes of importance:
Coronary artery disease

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? **No**

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? _____
If so, specify _____

(Signed) **F. E. Chase**, M. D.
(Address) **3133 Parkside Ave**

