

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.

OCT 4 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

791
100832730
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City, St. Louis Mo. (d) Street No., 4991 Tholozan Ave. Registered No. 8784
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Louisa Killian

(a) Residence, No. 4991 Tholozan Ave. St. 14
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas J. Killian
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 2 1860
 7. AGE YEARS 76 MONTHS 11 DAYS 16 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Hok.
 9. Industry or business in which work was done, as saw mill, bank, etc. at home
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

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

13. NAME Jacob Cass

14. BIRTHPLACE (CITY OR TOWN) Ohio
 (STATE OR COUNTRY)

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

17. INFORMANT Ben F. Killian
 (ADDRESS) 4991a Tholozan Ave.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Old S.S. Peter & Paul 9-21-37,

19. FUNERAL DIRECTOR Kriegshauser Mortuaries
 (ADDRESS) 4228 S. Kingshighway Blvd.

20. FILED SEP 20 1937 19 St. Bredeck
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 18 1937

22. I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1937, to Sept 18, 1937
 I last saw him alive on Sept 18, 1937. Death is said to have occurred on the date stated above, at 10:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage
hypertension

Other contributory causes of importance
Ch. hypert.

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

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 Arthur Sundback M. D.
 (Signed) (Address) 2202 University St.

Dr. Bunchbach University, Ill.
12-2

STATEMENT BY LICENSED EMBALMER

I, Reinhold K. Lohmann, Licensed Embalmer No. 9395

hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself
..... L. E.

No. or by, Registered Apprentice No.
working under my personal supervision.

Signed Reinhold K. Lohmann

Licensed Embalmer No.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)