

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

33004

Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003**
 (c) City **St. Louis** (d) Street No. **En route to Hosp #1** Registered No. **9058**
 (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

Harry Kitchner
 (a) Residence, No. **4549 Mc Millan** St. **12**
 (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 **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 **Mollie Kitchner**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Dec. 15, 1897**
 7. AGE YEARS **39** MONTHS **9** DAYS **12** If LESS than 1 day, ... hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Retail**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Groceries & Meats**
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation
 OCCUPATION

12. BIRTHPLACE (CITY OR TOWN) **Podolia**
 (STATE OR COUNTRY) **U.S.S.R.**

FATHER 13. NAME **Frank Kitchner**
 14. BIRTHPLACE (CITY OR TOWN) **U.S.S.R.**
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME **Lizzie Dilinsky**
 16. BIRTHPLACE (CITY OR TOWN) **U.S.S.R.**
 (STATE OR COUNTRY)

17. INFORMANT **Mrs. Mollie Kitchner**
 (ADDRESS) **4549 Mc Millan**

18. BURIAL, CREMATION, OR REMOVAL
 PLACE **CHESEBROUGH EARTH** DATE **9-29-37**

19. FUNERAL DIRECTOR **W.B. Berger**
 (ADDRESS) **4714 W. 8th St. St. Louis**

20. FILED **SEP 28 1937**
J. J. Bredeck
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept 27** 19**37**

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw him alive on 19..... Death is said to have occurred on the date stated above, at **6:30 A.M.**

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

Gunshot wound in head perforating brain and Haemorrhage, inflicted at the hands of one, Earl James, Col. about 6:30 o'clock A.M., Sept. 27, 1937, at 4364 Finney Ave.

Other contributory causes of importance: **Homicide.**

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

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **homicide** Date of injury **9/27** 19**37**

Where did injury occur? **St. Louis, Mo.**
 (Specify city or town, county, and State)

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

Manner of injury **see above**

Nature of injury **see above**

24. Was disease or injury in any way related to occupation of deceased? **no**

If so, specify **Alfred W. Perry, M.D.**

(Signed) **Deputy Coroner**

STATEMENT BY LICENSED EMBALMER

I, Herbert Berger, Licensed Embalmer No. 1597

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E.

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

Signed Herbert Berger

Licensed Embalmer No. 1597

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.)