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.

DEC 12 1938

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

791
1003

37168
Do not use this space.
9495

1. PLACE OF DEATH

(a) County ..... Registration District No. .....

(b) Township ..... Primary Registration District No. ..... Registered No. .....

(c) City St. Louis (d) Street No. City Hospital No. 1 St.

(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.

D. 9290 5TH

2. PRINT FULL NAME Peter Kuehn

(a) Residence, No. 640 Red Bud St. 9

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
male	white	married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 15, 1870

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
68	2	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as saw mill, bank, etc. nil

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. Louis, Missouri

FATHER

13. NAME AUGUST KUEHN

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

MOTHER

15. MAIDEN NAME DONT KNOW.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DONT KNOW.

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. ~~BURIAL~~, CREMATION, ~~OR REMOVAL~~ PLACE VALHALLA DATE 11/2 1938

19. FUNERAL DIRECTOR (NAME) W. G. Stock Undt. (ADDRESS) 2117 E. Grand

20. FILED NOV 1 1938 Jos. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/30/38, 19

22. I HEREBY CERTIFY, That I attended deceased from 9/25/38, 19, to 10/30/38, 19

I last saw him alive on 10/30/38, 19. Death is said to have occurred on the date stated above, at 7/10 m

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

	Date of onset
hypnphosarcoma of throat	

Other contributory causes of importance:

Bronchopneumonia

Ext. carotid

Name of operation Ligation of left ..... Date of 9/30/38

What test confirmed diagnosis? Biopsy ..... 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 .....

(Signed) Thos. J. Slaughter, M. D.

(Address) 1515 Lafayette.

Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

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

Signed Frank A. [illegible]

Licensed Embalmer No. 3041

P. O. Address 2117 E. [illegible]

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

If this body is not embalmed, above space should be left blank.