

22 22 1938

REC'D JAN 6 1939

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

44472  
Do not use this space.

1. PLACE OF DEATH  
 (a) County St. Louis Registration District No. 784  
 (b) Township Overland Primary Registration District No. 305 Registered No. 2091  
 (c) City Overland (d) Street No. 9411 Lackland 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.

2. PRINT FULL NAME Carl G. Kielmann  
 (a) Residence, No. 9411 Lackland ave St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

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 anna (Christensen)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 2 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
65 no 17

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. ✓  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation 40

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Denmark 7

FATHER  
 13. NAME Edward Kielmann  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Denmark 7

MOTHER  
 15. MAIDEN NAME Elizabeth Larson  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Denmark 7

17. INFORMANT (ADDRESS) Anna Kielmann 9411 Lackland

18. BURIAL, CREMATION, OR REMOVAL PLACE Lake Charles DATE Dec 23 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Bannan Bros Overland Mo  
W. R. Meyer M.D. Overland Mo

20. FILED DEC 22 1938 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec-19- 1938

22. I HEREBY CERTIFY, That I attended deceased from May 14- 1936 to Dec-19- 1938  
 I last saw him alive on Dec-19- 1938. Death is said to have occurred on the date stated above, at 5:30 m.  
 The principal cause of death and related causes of importance were as follows:  
Hemorrhage of bowel  
if  
 Other contributory causes of importance:  
Carcinoma of rectum May 14/36

Name of operation Colostomy Date of May 16 1936  
 What test confirmed diagnosis? biopsy Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? No 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 Ray Swetter M. D.  
 (Address) 12438 Woodson Rd. Overland, Mo.

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.

**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, .....

*Carl L. Killerman*

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

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

Signed.....

*Carl L. Killerman*

Licensed Embalmer No. ....

*3501*

P. O. Address .....

*Coverland, mo.*

**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.)**

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

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

44472

Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis  
(b) Township  
(c) City Overland  
(e) Length of residence in city or town where death occurred

Registration District No. 784  
Primary Registration District No. 200

Registered No. ....

(d) Street No. .... St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

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

Carl G. Killmann

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
65 - 17

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
9. Industry or business in which work was done, as 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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 19 1938

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

I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.

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

Date of onset

Other contributory causes of importance:

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? .....

If so, specify

(Signed) Ray A. Walker, M. D.

(Address) 3448 Broadway Rd Overland Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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