

APR 12 1939

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

9159
Do not use this space.

1. PLACE OF DEATH

(a) County..... / Registration District No..... 791
(b) Township..... / Primary Registration District No..... 1008
(c) City..... St. Louis..... (d) Street No..... City Hospital #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.

2. PRINT FULL NAME CHARLES KEMETER

(a) Residence, No. 307 North Garrison St. 21 (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 Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) December 17 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
65 3 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Barber
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) New York City (STATE OR COUNTRY) New York

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT Mrs Clara Kemeter (ADDRESS) 307 North Garrison Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Valhalla Crematory DATE March 30 1939

19. FUNERAL DIRECTOR (NAME) Mullen Bros (ADDRESS) 4259 Lindell Blvd

20. FILED MAR 28 1939 J. B. Brubaker Local Registrar

NON-ATTENDING PHYSICIAN

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 27 1939

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

I last saw h. _____ alive on _____ 3:05 P.M. Death is said to have occurred on the date stated above, at _____

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

Fracture of left hip/ Chronic Myocarditis; Edema of Lung; Chronic Nephritis; suffered in fall on icy pavement in front of 3501 Olive Street, Feb. 25th, 1939, about 10:00 P.M.

Other contributory causes of importance? 186a 39

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? Accident Date of injury 2/25/ 19. 39

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. In Public Place

Manner of injury See Above

Nature of injury _____

24. Was disease of injury in any way related to occupation of deceased? No

If so, specify _____ (Signed) _____

(Address) _____ Deputy Coroner

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, or by.....

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

Signed *Howard F Rowland*

Licensed Embalmer No. *3114*

P. O. Address.....

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.