

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

791
1008

16691
Do not use this space.

1939 JUN 12 1939

1. PLACE OF DEATH
 (a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 or St. Louis, Mo. City Infirmery.
 (c) City..... (d) Street No..... St.
 (e) Length of residence in city or town where death occurred Life yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 455 George C. Kuhlmann
 (a) Residence, No. 5800 Arsenal St. St. 13
 (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) Divorced
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sadie Hawes.
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) February 15, 1889
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
 50 2 27
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clerk.
 9. Industry or business in which work was done, as saw mill, bank, etc. Bartender.
 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. 0
 FATHER
 13. NAME Henry Kuhlmann 9
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown. 9
 MOTHER
 15. MAIDEN NAME Marie Freeze
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown.
 17. INFORMANT (ADDRESS) E. Molony, 5800 Arsenal St.
 18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE 5-6-39 19
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) City of St. Louis, Ryan
 20. FILED MAY 6 1939 1939 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 3, 1939
 22. I HEREBY CERTIFY, That I attended deceased from January 21, 1937, May 3, 1939
 I last saw h. im. alive on May 3, 1939 Death is said to have occurred on the date stated above, at 3:45 m. P.M.
 The principal cause of death and related causes of importance were as follows:
 Cerebral Thrombosis
 Other contributory causes of importance:
 Old Hemiplegia
 Hypertension
 Chronic Myocarditis
 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?..... 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) J. Potashnick, M. D.
 (Address).....

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.....

Licensed Embalmer No.....

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.