

1939 JUL 13 1939

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

22436
Do not use this space.

1. PLACE OF DEATH

(a) County JEFFERSON Registration District No. 445-1
 (b) Township MERAMEC Primary Registration District No. 3580
 (c) City _____ (d) Street No. ST. JOSEPH'S HILL INFIRMARY - EUREKA, MO. 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. 10 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME FRANK H. KILB

(a) Residence, No. 4335 MINNESOTA AVE. ST. LOUIS, MO. 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 KATHERINE NETTEKER
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8/26/1879
 7. AGE YEARS MONTHS DAYS IF LESS THAN 1 DAY, HRS. OR MIN.
59 9 19
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. SHIPPING CLERK
 9. Industry or business in which work was done, as saw mill, bank, etc. WIZARD FOOT APPLIANCE CO. ST. LOUIS, MO.
 10. Date deceased last worked at this occupation (month and year) MAY 11, 1939
 11. Total time (years) spent in this occupation 23

12. BIRTHPLACE (CITY OR TOWN) ST. LOUIS, MO.
 (STATE OR COUNTRY)

13. NAME Dont know
 14. BIRTHPLACE (CITY OR TOWN) Dont know
 (STATE OR COUNTRY)

15. MAIDEN NAME Dont know
 16. BIRTHPLACE (CITY OR TOWN) Dont know
 (STATE OR COUNTRY)

17. INFORMANT ST. JOSEPH'S HILL INFIRMARY
 (ADDRESS) Brother Bonaventure, O. S. F.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Peter & Paul Cem. DATE June 16, 1939

19. FUNERAL DIRECTOR (NAME) A. N. Getken & Co.
 (ADDRESS) 2842 Myriam St.

20. FILED 4 July 1939 James A. Dwyer
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-14-39 19
 22. I HEREBY CERTIFY, That I attended deceased from June 9, 1939, to June 13, 1939
 I last saw him alive on June 9, 1939. Death is said to have occurred on the date stated above, at 4:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Chronic Endocarditis
 Other contributory causes of importance: 920

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? No.

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 Jesse S. Sargent, M. D.
 (Signed) _____ (Address) Eureka, 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.

56

WHILE PLAINLY WITH UNWADING INK—THIS IS A PERMANENT RECORD

1 X14028

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 Herman A. Gebken

Licensed Embalmer No. 2120

P. O. Address St. Louis 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 12-18

1. PLACE OF DEATH:

(a) County _____
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph's Hill Infirmery
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 days
 (Specify whether _____)
 In this community 10 days
 years, months or days)

3. (a) PRINT ⁴⁵⁷ FULL NAME Frank H. Kill

3. (b) If veteran, name war No 3. (c) Social Security No. 488-10-9914

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Catherine (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Aug. 26, 1879
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>9</u>	<u>16</u>	hr. _____ min.

9. Birthplace St. Louis, Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Shipping Clerk

11. Industry or business Wizard Co.

12. Name Nicholas Kill

13. Birthplace Germany
 (City, town, or county) (State or foreign country)

14. Maiden name Anna Dellermann

15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Catherine Kill

(b) Address 4335 Minnesota Ave.

17. (a) Burial (b) Date thereof June 17, 1959
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SS. Peter & Paul Cem

18. (a) Signature of funeral director J. H. Gebken L. & U. Co

(b) Address 2842 Meramec St.

19. (a) 14 Jun (b) James A. Townsend
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4335 Minnesota Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

FORM 1 X 35811

S-22434

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.