

STANDARD CERTIFICATE OF DEATH

State File No. **34535**

Registration District No. **1008**

Primary Registration District No. _____

Registrar's No. **9073**

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Lutheran Hosp.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 week
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME August Kugler 24th

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

6. (b) Name of husband or wife Indie Kugler 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased May 26 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>4</u>	<u>27</u>	hr. _____ min. _____

9. Birthplace Centralia Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Sign Painter

11. Industry or business _____

12. Name Jacob Kugler

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

14. Maiden name Philippine Lingenfelder

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

16. (a) Informant's own signature Mrs. Margout Becker

(b) Address 2631 S 18th

17. (a) Burial (b) Date thereof 10-26-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cem

18. (a) Signature of funeral director Walt Broad

(b) Address 2929 S. Jefferson Av.

19. (a) OCT 25 1939 (b) J. F. Gedick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St. Louis 24
(If outside city or town limits, write "RURAL")
 (d) Street No. 3613 S. Broadway
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23
 year 1939 hour 3:30 p.m. minute _____ M.

21. I hereby certify that I attended the deceased from Oct 13, 1939
 _____, 19____, to Oct 23, 1939
 that I last saw him alive on Oct 23, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute cardiac dilatation Duration 30 min.

Due to aortitis 3 years

Due to syphilis 3 1/2 years

Other conditions secondary anemia 1 week
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration

30 min.

3 years

3 1/2 years

1 week

PHYSICIAN

Underline the cause to which death should be charged statistically

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) (b) Means of injury

23. Signature Burchard Hunt (M. D. or other) M.D.

Address 6006 Virginia Avenue Date signed 10/24/39

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.

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 _____

Paul W. Shanklin
working under my personal supervision.

Registered Apprentice No. _____

Signed _____

Paul W. Shanklin
Licensed Embalmer No. 3472

P. O. Address 9929 S. Jeff.

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.