

Registration District No. **791** Primary Registration District No. **1003**

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

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:
City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Hr
(Specify whether
In this community
years, months or days)

8. (a) PRINT FULL NAME **JOSEPH KAHR**

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Kahr 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Nov. 20 Th 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 ----- 2 -- 16 + hr. min.

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

10. Usual occupation Laborer

11. Industry or business Retired

12. Name Joseph Kahr

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

14. Maiden name Not known

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

16. (a) Informant Mary Kahr

(b) Address 3412 Klein Str 1940

17. (a) Burial (b) Date thereof Feb. 7 TH
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Edward Koch

(b) Address 3516 N. 14. Th Str

19. (a) FEB 6 1940 (b) J. P. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis Mo 26
(If outside city or town limit write "RURAL")
(d) Street No. 3412 Klein Str
(If rural, give location)
(e) If foreign born, how long in U. S. A. 27 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 5 TH
year 1940 hour 3 minute AM M.

21. I hereby certify that I attended the deceased from Dec 14
1939 to Feb 5 1940
that I last saw him alive on Jan 30 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis
(non Bacteriemia)

Due to "Phlebotomism"

Other conditions Artificial Sclerosis

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following: no
(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 J. P. ... (M. D. or other)
Address 4244 N. Flouissant Date signed 2/5/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Harry J. Schunacker

Licensed Embalmer No. 2679

P. O. Address 732 Kemar

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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