

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8968

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2451

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2012 College Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

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. 2012 College Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Elizabeth Kutscher
(b) If veteran, name war _____ (c) Social Security No. _____
4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Charles Kutscher 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug. 9, 1857
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 12
year 1940 hour 5 minute P. M.
21. I hereby certify that I attended the deceased from March 10, 1939, to March 12, 1940
that I last saw her alive on March 12, 1940
and that death occurred on the date and hour stated above.

8. AGE: Years 82 Months 7 Days 3 If less than one day _____ hr. _____ min.
9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation At Home

Immediate cause of death Chronic Myocarditis
Due to arteriosclerosis
Due to Senility
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER
11. Industry or business _____
12. Name Michael Koerber
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Germany
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.
Senility

16. (a) Informant Mrs. Agnes Frank
(b) Address 2012 College Ave.
17. (a) Burial (b) Date thereof 3/15/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director W. Astock
(b) Address 2517 Grand Blvd.
19. (a) MAR 15 1940 (b) J. F. Bredel
(Date received local registrar) (Registrar's signature)

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 J. F. Bredel M. D. or other _____
Address 600 S. W. Filson signed 3-13-40

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

De Maria

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

Frank A. Moore

Licensed Embalmer No.

3041

P. O. Address

2117 E Grand

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.