

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.

MAY 24 1940
Registration District No. 784

Primary Registration District No. 111

State File No. _____

Registrar's No. 977

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary Hospital
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution 4 weeks
(Specify whether
In this community life
years, months or days)

3. (a) PRINT FULL NAME Arnold B. Kaufmann 155

8. (b) If veteran, name war World War (c) Social Security No. 492-01-6792

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

(b) Name of husband or wife Celia Kuechler 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased August 7 1897
(Month) (Day) (Year)

8. AGE: Years 43 Months 9 Days 12 If less than one day
hr. min.

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

10. Usual occupation Shoe Worker 9

11. Industry or business International Shoe Co. 9

MOTHER FATHER { 12. Name Melchoir Kaufmann 6

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

14. Maiden name Anna August
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Celia Kaufmann

(b) Address 4623 Ray Ave.

17. (a) Burial (b) Date thereof May 22, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director John Ziegenhain & Sons

(b) Address 7027 Graves Ave.

19. (a) MAY 22 1940 (b) R. R. Meyer
(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. 4623 Ray Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19
year 1940 hour 2 minute A. M.

21. I hereby certify that I attended the deceased from 4/7/40
4/7, 1940 to May 2 1940
that I last saw her alive on May 18 1940
and that death occurred on the date and hour stated above.

Immediate cause of death. Cause of large Bowel

Due to _____

Due to 46

Other conditions (Include pregnancy within 3 months of death)

Major findings: Cause of Bowel
Of operations _____

Of autopsy _____

Duration

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)
(e) Means of injury _____

23. Signature W. R. Meyer (M. D. or other)

Address 729 N. North Blvd Date signed 5/19/40

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..... *E. P. Kidwell*

Licensed Embalmer No. *3877*

P. O. Address *69379 Grange*

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.

FR 760

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16116
Registrar's No. 977

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 784

Primary Registration District No. 111

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

1. PLACE OF DEATH
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: St. Mary Hosp.
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____
(d) Street No. _____
(e) If foreign born, how long in U.S.A.? _____ years.

3. (a) PRINT FULL NAME Arnold B Kaufmann
(b) If veteran, name war _____
(c) Social Security No. _____

20. DATE OF DEATH: Month May day 19
year _____ hour _____ minute _____ M.

4. Sex m 5. Color or race w
6. (b) Name of husband or wife _____
7. Birth date of deceased Aug 7 1897
(Month) (Day) (Year)

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

8. AGE: Years 43 Months 9 Days 12
If less than one day _____ hr. _____ min.

Immediate cause of death _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____

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 _____

19. (a) 5-22-40 (b) T.R. Meyer
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) _____
Address _____ Date signed _____

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