

FILED AUG 28 1941

Registration District No. 791

Primary Registration District No. \_\_\_\_\_

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:  
Enroute City Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 (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. 3859 Botanical Ave.  
(If rural, give location)  
(e) Citizen of foreign country? No Attending Physician (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Walton Kaulen  
3. (b) If veteran, name war No.  
3. (c) Social Security No. 488-40-6807

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

6. (b) Name of husband or wife Grace 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased July 6 1905  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>35</u>	<u>11</u>	<u>24</u>	hr. _____ min. _____

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

10. Usual occupation Barber

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Frank Kaulen

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

14. Maiden name Emma Perrea

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

16. (a) Informant Dr. P. J. Kaulen

(b) Address Overland, Mo.

17. (a) Burial (b) Date thereof 7/2/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) JUL 2 1941 (b) J. Budeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1  
year 1941 hour 8 minute 35 P.M.

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.

Immediate cause of death Gunshot Wound of Skull and Brain Self Inflicted  
Duration \_\_\_\_\_  
Due to at his home 3859 Botanical ave June 30 - 1941  
About 12:05 Pm

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 16 167

Of autopsy \_\_\_\_\_

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) Suicide

(b) Date of occurrence June 30 - 1941

(c) Where did injury occur? St. Louis Mo  
(City or town) (County) (State)

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

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

23. Signature Thomas J. Callahan (M. D. or other) 3

Address Deputy Coroner Date signed \_\_\_\_\_

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

*R. G. W.  
Howell*

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**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 *Albert G. Koffer*  
.....  
Licensed Embalmer No. *2991*

P. O. Address.....

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

**If this body is not embalmed, fact should be so stated above.**