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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33349 8304

Registration District No. 791

Primary Registration District No. 1003

Registrar's 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:
601 Loughborough ave. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Life (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17

(c) City or town St. Louis 9 I
(If outside city or town limits, write "RURAL") 0

(d) Street No. 601 Loughborough ave.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Laura Johnston Kalb

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Charles R. Kalb

6. (c) Age of husband or wife if alive years

7. Birth date of deceased December (Month) 23 (Day) 1872 (Year)

8. AGE: Years 68 Months 9 Days 24 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name James Johnston
13. Birthplace Belfast (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Alice Chapman
15. Birthplace Pittsburg (City, town, or county) Pennsylvania (State or foreign country)

16. (a) Informant Mrs Alice Johnston Doering
(b) Address 601 Loughborough ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof October 20, 41 (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director C Hoffmeister N & L Co.
(b) Address 7814 S. Broadway

19. (a) OCT 20 1941 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 17
year 1941 hour 5 minute 30 a. M.

21. I hereby certify that I attended the deceased from Sept 1 1941 to Oct 17 1941;
that I last saw her alive on Oct 17 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Fruit Cordiac Decompensation — Duration 11 days

Due to Chronic Myocarditis — 10 yrs

Due to 98

Other conditions Arthritis Deformans — 30 yrs
(Include pregnancy within 3 months of death)
Paralysis Agitans — 2 yrs

Major findings:
Of operations ✓
Of autopsy ✓ 930

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature H. F. Overland (M. D. or other) M.D.
Address 5930 Southwest Ave Date signed 10-18-41

(Licensed Embalmer's Statement on Reverse Side)

3-5 PM.

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 Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broo

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

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