

Registration District No. 318

Primary, Registration District No. 1003

Registrar's No. 333896

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: St. John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months
(Specify whether years, months or days)

In this community 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Overland
(If outside city or town limits, write "RURAL")

(d) Street No. 9205 Wabaday
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME HENRIETTA KERN

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex W.F. 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wm. F. Kern 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Nov. 29 1882
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>4</u>	<u>9</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Own home

MOTHER FATHER

12. Name Oliver P. Lash

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

14. Maiden name Eva Fischer

15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Eva Erickson

(b) Address 9205 Wabaday Overland Mo

17. (a) Burial (b) Date thereof Apr. 10 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Free Free Cem.

18. (a) Signature of funeral director Burman Bros. Inc.
(b) Address 2504 Woodson Rd - Overland, Mo.

19. (a) APR 9 1943 (b) J. F. Bracke
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8
year 1943 hour 9 minute A. M.

21. I hereby certify that I attended the deceased from 11-10
1940, to 4-8 1943
that I last saw her alive on 4-8 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac Decompenation Duration 2 yrs.

Due to Hypertension 4 yrs.

Due to nephritis Chronic 3 yrs.

Other conditions Yes
(Include pregnancy within 3 months of death)

Major findings: 12/1

Of operations _____

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) _____

(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 Norman J. Klaeber (M. D. or other) MD
Address 9621 Radford Rd Date signed 4-8-43

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.....

Oscar F. Mueller

Licensed Embalmer No.....

3039

P. O. Address.....

Overland Mo

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, fact should be so stated above.