

S. No. 2
M-2-43
5-17-34
1 X3567

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

30090

State File No.

Registrar's No.

8315

Registration District No. 318

Primary Registration District No. 1003

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

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:
Good Samaritan Home, 4500 Washington Blvd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 Months 5
(Specify whether
In this community ?
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County osc
(c) City or town St. Louis 1217
(If outside city or town limits, write "RURAL") 9
(d) Street No. 4500 Washington Blvd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country U

3. (a) PRINT FULL NAME Barbara Kellner

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife George Kellner 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased December 8, 1863.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 9 0 hr. 11 min.

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

10. Usual occupation None

11. Industry or business _____

12. Name Max Salzman

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)

16. (a) Informant Rev. J. H. Overbeck, Supt.

(b) Address 4500 Washington Blvd.

17. (a) Burial (b) Date thereof Sept. 20, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Calvin F. Feutz Funeral Home

(b) Address 4828 Natural Bridge Blvd.

19. (a) SEP 20 1943 (b) J. F. Bredek
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19th,
year 1943 hour 6:30 minute A. 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 Cerebral Occlusion
arterial occlusion

Due to _____

Due to 9 if

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

Major findings: 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)
(c) Means of injury _____

23. Signature: James J. [unclear] (M.D. or other)
Address 1300 [unclear] Date signed 9/20/43

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 John A. Mlinar
Licensed Embalmer No. 4186
P. O. Address St. Louis, 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.