

FILED OCT 19 1943

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2318

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Rural- Gravois  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Millers Nursing Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community about 74 years. (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000  
(a) State Missouri (b) County 17  
(c) City or town City of St. Louis 9  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5629 Rosa Avenue  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Augusta Noll  
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 unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE: Years about 74 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation none

11. Industry or business none

12. Name August Kienast

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

14. Maiden name Marie Poutrup

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

16. (a) Informant Mrs. Theresa Mueller

(b) Address 5629 Rosa Avenue

17. (a) cremation (b) Date thereof 10-15-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Southern Funeral Home

(b) Address 6322 So. Grand Blvd.

19. (a) OCT 15 1943 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 13 th  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ PM.

21. I hereby certify that I attended the deceased from  
Oct. 5th 1943 to Oct. 13th 1943  
that I last saw her alive on October 12th, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Duration  
4 days

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Fell-Injury to left hip  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations [Signature]

Of autopsy No

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) Fell-injury to left hip

(b) Date of occurrence October 5th, 1943

(c) Where did injury occur? 5629 Rosa Av.  
(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 [Signature] (M. D. or D. O.)

Address 3608. Grand Blvd. Date signed 10/14/43

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

MOTHER FATHER

La 7891

Dr. Walters  
Grand & Leavies

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

*Virgil L. Berryman*

Licensed Embalmer No.

4018

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.**