

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

1. PLACE OF DEATH:  
(a) County ST LOUIS  
(b) City or town KOCH  
(c) Name of hospital or institution: ROBERT KOCH HOSP.  
(d) Length of stay: In hospital or institution 3 mo 18 days  
In this community 20 years

3. (a) PRINT FULL NAME HART, CARL  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. yes

4. Sex M 5. Color or Race C  
6. (a) Single, widowed, married, divorced SO  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased MAY 11 1923

8. AGE: Years 20 Months 6 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace ST LOUIS MO

10. Usual occupation CHAUFFEUR

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name EDDIE HART  
13. Birthplace \_\_\_\_\_  
14. Maiden name GERTRUDE  
15. Birthplace \_\_\_\_\_

16. (a) Informant Hospital Record  
(b) Address Robert Koch Hosp

17. (a) Buried (b) Date thereof 12/16-43  
(c) Place of burial or cremation St. Louis City Cemetery

18. (a) Signature of funeral director W. V. Whit  
(b) Address City Hospital NO 1

19. DEC 16 1943 (b) E. J. McDevran, M.D.

2. USUAL RESIDENCE OF DECEASED: 000  
(a) State Missouri (b) County 17  
(c) City or town St Louis  
(d) Street No. 4346 a PAGE  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 24  
year 1943 hour 8 minute 20 A.M.  
21. I hereby certify that I attended the deceased from Aug 6 1943 to Nov 24 1943  
that I last saw him alive on Nov 24 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration June 1943

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

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy Pulm. Tuberculosis 1361  
PHYSICIAN \_\_\_\_\_

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? \_\_\_\_\_  
(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 Frank Cohen M.D. (M. D. or other) \_\_\_\_\_  
Address Robert Koch Hosp Date signed 11/25/43

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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 *Malter A. McPauland Jr*

Licensed Embalmer No. *4361*

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.**