

13015

No. 2
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5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 2 1944

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3786**

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:
2834a Missouri Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Ida M. H. Koons**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **David M.** 6. (c) Age of husband or wife if alive **74** years
7. Birth date of deceased **Feb. 6 1872**
(Month) (Day) (Year)

8. AGE: Years **72** Months **2** Days **16** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Home**

11. Industry or business **Jacob Schlitter**

12. Name **Jacob Schlitter**

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

14. Maiden name **Mary**

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

16. (a) Informant **Lillian S. Koons**

(b) Address **2834a Missouri Ave.**

17. (a) **Burial** (b) Date thereof **Apr. 25, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **Walter Helderle**

(b) Address **3634 Gravois Ave.**

19. (a) **APR 24 1944** (b) **J. F. Brudick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2834a Missouri Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **22**
year **1944** hour **12** minute **10** A.M.

21. I hereby certify that I attended the deceased from **April 4** 19**44** to **April 22** 19**44**
that I last saw her alive on **April 21** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Intestinal Obstruction**
Myocardial Collopa
Cerebral Sigmoid
Due to _____

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

Major findings: **H/O**
Of operations _____
Of autopsy _____

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 **Leo Young** (M. D. or other) **MD**
Address **2621 S. Jefferson** Date signed **4/24/44**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
Dr. L. P. Young

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.....

Robert C. Wheeler

Licensed Embalmer No.....

2178

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.

Registration District No. 318

Primary Registration District No. 1003

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1. PLACE OF DEATH:

(a) County St. Louis Mo
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ida M. G. Koons
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month 4 day 22
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex _____ 5. Color or race _____
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____
8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr _____ min.

9. Birthplace: (City, town, or county) _____ (State or foreign country) _____
10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country) _____
14. Maiden name Mary Linkogel
15. Birthplace _____ (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____
19. (a) 5-12-44 (b) J. F. Bredack
(Date received local registrar) _____ (Registrar's signature)

Duration _____
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: 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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

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