. S. No. 2
DM—8-43
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 15 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36076

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10496

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: Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2926 Tamm Ave.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Margaret Kohlhauff
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 Widow
6. (b) Name of husband or wife Albert
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sep. (Month) 22 (Day) 1863 (Year)

8. AGE: Years 81 Months 2 Days 15 If less than one day hr. min.

9. Birthplace (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Home
11. Industry or business
FATHER
12. Name John Rappold
13. Birthplace (City, town, or county) Unknown (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Mrs. Anna Zorn
(b) Address 2926 Tamm Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cemetery
18. (a) Signature of funeral director Wacker Helderle
(b) Address 3634 Gravois Ave.
19. (a) DEC 9 1944 (Date received local registrar) (b) J. F. Budick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6
year 1944 hour 9 minute 50 P. M.
21. I hereby certify that I attended the deceased from Dec. 2, 1944, to Dec. 6, 1944
that I last saw her alive on Dec. 6, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Trochanteric fracture left hip	5 days
Due to	
Due to Fall at home	
Other conditions General arteriosclerosis (Include pregnancy within 3 months of death)	20 yrs.
Major findings: Of operations Trochanteric fracture left femur	
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) Accident
(b) Date of occurrence Nov 19 1944
(c) Where did injury occur? Home St Louis (City or town) Missouri (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home, 2926 Tamm Ave (Specify type of place)
While at work? No (e) Means of injury fall
23. Signature P. P. Brookes M. D. (M. D. or other)
Address 1652 S. Grand Blvd Date signed 12/3/44

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 9675

P. O. Address.....

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.