

FILED JAN 25 1945

Registration District No. 318

Primary Registration District No. 1003

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:  
Park Lane Memorial Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 days (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME MRS BARBARA Kimmick

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, widowed

6. (b) Name of husband or wife Jacob Kimmich 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased October 10, 1896  
(Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Not known Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name Hochstaedter

13. Birthplace Not known Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Geroge Kimmich

(b) Address 6709 Morganford

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 1/17/45  
(Month) (Day) (Year)

(c) Place: burial or cremation St Peter & Paul

18. (a) Signature of funeral director J L Ziegenhein & Sons

(b) Address 7027 Gravois

19. (a) JAN 10 1945 (Date received local registrar) (b) J. F. Brudek (Registrar's signature)

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. 2019 Miami  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 8  
year 1945 hour 11 minute 30 A M.

21. I hereby certify that I attended the deceased from Dec.  
28th, 1944, to JAN 8, 1945;  
that I last saw her alive on JAN 8, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Chr. Myo Carditis  
Chr. Nephritis  
Due to Hypertension

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

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

Major findings:  
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 J. F. Brudek (M. D. or other) M.D.

Address 4932 Lindell Blvd Date signed 1-8-45

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

MOTHER FATHER

Duration

SEVERAL  
Years

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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..... *C. P. Kudweel* .....

Licensed Embalmer No. *3877* .....

P. O. Address *7027 Travis* .....

**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.**