

FILED FEB 7 1945

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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:  
5450 Cologne 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 August J. Kohrmann

3. (b) If veteran, name war \*\*\*\*\* 3. (c) Social Security No. 493-09-9169

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased May 16th, 1880  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>8</u>	<u>11</u>	hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Sheet Metal Worker

MOTHER FATHER

12. Name Louis G. Kohrmann

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

14. Maiden name Mary Wilmas

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

16. (a) Informant Mrs. Mary Burchler  
(b) Address 5450 Cologne Ave

17. (a) Burial (b) Date thereof 1-30-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ziegenhein Prov.

18. (a) Signature of funeral director 6409 Gravois Ave  
(b) Address New St. Peter's Church

19. (a) JAN 29 1945 (b) J. F. Bredeek  
(Date received local registrar) (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. 5450 Cologne Ave  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 27th day January  
year 1945 hour 9:30 minute A. M.

21. I hereby certify that I attended the deceased from Dec 11, 1944, to Jan 29, 1945  
that I last saw him alive on Jan 26, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Regurgitation

Due to Hypertensive Chronic Pericarditis Nephritis

Due to Acute Softening of the Brain Arteriosclerosis

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)

23. Signature: E. A. Schuessinger (a) \_\_\_\_\_ (b) \_\_\_\_\_  
Address: 4420 Delmar & Bldg Date signed 1-29-45

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

*Dr Selwynson  
4470 Natwick Bridge  
50-5779  
8-10-11 to 7:05*

**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 *Homer W. Priddy*  
Licensed Embalmer No. 3882

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.**