

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7150
Registrar's No. 415

FILED FEB 24 1945
Registration District No. 377

Primary Registration District No. 3070

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Webster Groves,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
8 Armin Place, Webster Groves, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 74 years
years, months or days

3. (a) PRINT FULL NAME Mrs. Bertha F. Kadell

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 Charles W. Kadell 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 25, 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

74 11 15 _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name Mr. Arnold Hussmann

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

14. Maiden name Susanna Eckert

15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Vera Kadell

(b) Address # 8 Armin Place, W. G., Mo.

17. (a) Burial (b) Date thereof Feb. 12, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Beiderwieden F. H., Inc.

(b) Address 1936 St. Louis Avenue

19. (a) FEB 14 1945 (b) E. G. M. Gorman
(Date received local registrar) (Registrar's signature)

(Licensed Emballer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 76

(c) City or town Webster Groves,
(If outside city or town limits, write "RURAL")

(d) Street No. # 8 Armin Place
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 9,
year 1945 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from 10-24
1945, to 2-9-45, 19____;
that I last saw her alive on 2/8/45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Dilatation Duration 1 Day

Due to myocarditis chronic Type Type

Due to Hypertension Type Type

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

Major findings: _____

Of operations 93rd

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? _____

(Specify type of place)

While at work _____ (e) Means of injury _____

23. Signature R. A. Heshie (M. D. or other) md

Address Webster Groves, Mo Date signed 2/14/45

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..... *Julius J. Krupin*

Licensed Embalmer No. *3497*

P. O. Address *1936 St. Louis Ave*

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.