

U. S. No. 2
DOM-5-43
Rev. 5-17-39
I X36671

FILED MAR 23 1945

Registration District No. **318** Primary Registration District No. **1002** Registrar's No. **2261**

1. PLACE OF DEATH: **318**

(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:
2828 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 _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **2828 Missouri**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT **Mathilda Kost**
FULL NAME

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 **George** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **October 6 1866**
(Month) (Day) (Year)

8. AGE: Years **78** Months **5** Days **2** If less than one day _____ hr. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** - day **8**
year **1945** - hour **2** minute **A. M.**

21. I hereby certify that I attended the deceased from **Dec. 1944** to **3-8-45** 1944 to 1945

that I last saw him **alive on 7th of March** 1945 and that death occurred on the date and hour stated above.

Immediate cause of death **myocarditis, Thy** Duration _____

Due to **Senility**

Due to **tumor of abdominal viscera - non-malignant**

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

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

10. Usual occupation **AT/ Home**

11. Industry or business _____

12. Name **Jacob Schlitter**

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

14. Maiden name **Mary Linkhoughel**

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

16. (a) Informant **Walter Kost**
(b) Address **2828 Missouri Ave.**

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

(c) Place: burial or cremation **ST. Pauls Churchyard**

18. (a) Signature of funeral director **John H. Glicker Sons**
(b) Address **2630 Grayola Ave.**

19. (a) **MAR 10 1945** (Date received local registrar) **J. D. Bredack** (Registrar's signature)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: **X**

Of operations _____

Of autopsy **X**

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 **L. F. Murray** (M. D. or other) **0**
Address **900-Russell** Date signed **3-8-45**

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

MOTHER FATHER

20
17
9

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

working under my personal supervision.

Registered Apprentice No.

Signed

Robert T. Glicker

Licensed Embalmer No.

4144

P.O. Address

2630 Grosvenor 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.