. S. No. 2
M—8-43
v. 5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 13 1945

Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

818

Primary Registration District No.

State File No. 7928

Registrar's No. 2980

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: 3959 Chippewa St. (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)

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. 3959 Chippewa St. (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Emma Kuhn

3. (b) If veteran, name war

3. (c) Social Security No. No.

4. Sex Female

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 (Month) 16 (Day) 1867 (Year)

8. AGE: Years 77 Months 10 Days 15 If less than one day hr. min.

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

10. Usual occupation Home

11. Industry or business

FATHER
12. Name Unknown
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 Arthur Stamm

(b) Address 3959 Chippewa St.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof Apr. 4, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Wacker Helderle

(b) Address 3634 Gravois Ave.

19. (a) APR 3 1945 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1 year 1945 hour 3 minute 35 P. M.

21. I hereby certify that I attended the deceased from 3-6-45, 19, to 4-1-, 1945 that I last saw her alive on 4-1-, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Cancer of Cecum	6 Mths
Major findings: Of operations	
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 C. F. Kloppel (M. D. or other)

Address 905 Morrison Av. Date signed 4/2/45

(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:.....

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.