

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18937**
Registrar's No. **5342**

MEI JUN 30 1945 318

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1mo-8days**
(Specify whether _____)
In this community **Life**
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. **1859a S. 13th Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Lydia Kull**

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 **Single**

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

7. Birth date of deceased **September 26, 1877**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	67	8	20	hr. _____ min. _____

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

10. Usual occupation **Housekeeper**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Kull**

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

14. Maiden name **Hika Kull**

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

16. (a) Informant **Joseph L. Kappel**

(b) Address **1859a S. 13th Street**

17. (a) **Burial** (b) Date thereof **June 18, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Paul Churchyard**

18. (a) Signature of funeral director **Wm C Mopell**

(b) Address **1926 Allen Avenue**

19. (a) **JUN 18 1945** (Date received local registrar) **J. F. Bredeek** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **16th**
year **1945** hour **3:00** minute _____ A. M.

21. I hereby certify that I attended the deceased from **5/8/45**
_____, 19____, to **6/16/45**, 19____;
that I last saw her alive on **6/16/45**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Carcinoma of the ovary ?

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **H9 a**

Major findings: Of operations _____

Of autopsy **Ammission refused**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Robert E. Holt, M.D.** (M. D. or other)
Address **1515 Lafayette 6/16/45**

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

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

Benny E. Duncan

Licensed Embalmer No.

2272

P. O. Address

1926 Allen Av

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.