

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29148

State File No.

8115

FILED SEP 21 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

06
17
9

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

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:
Christian Hospital 0
(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 Julia M. Kooh

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Not Given 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased May 3, 1873.
(Month) (Day) (Year)

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

72 4 12 hr. min.

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

10. Usual occupation Housework

11. Industry or business.....

MOTHER FATHER

12. Name Franz Kooh

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Mary Helmer

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. S. A. Levey
(b) Address 8050 Venetian Dr.

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

(c) Place: burial or cremation Chicago, Illinois.

18. (a) Signature of funeral director Calvin F. Peutz Funeral Home
(b) Address 4828 Natural Bridge Blvd.

19. (a) SEP 18 1945 (b) J. Fredrick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Clayton 2
(If outside city or town limits, write "RURAL")

(d) Street No. 8050 Venetian Dr. 3
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 1
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 15th
year 1945 hour 6:10 minute 4 M.

21. I hereby certify that I attended the deceased from Sept 6th, 1945, to Sept 15, 1945,
that I last saw him alive on Sept 14, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage 9 day
Hypertension
Arterial Sclerosis

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Duration
9 day

Major findings:
Of operations..... 831

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?.....

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

23. Signature Leo A. Mallon (M. D. or other)
Address 2739 7th Grand Date signed 9-15-45

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.....

John A. Mbur

Licensed Embalmer No. *4186*

P. O. Address *St. Louis Mo*

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.