V. S. No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

29151

State File No.

FILED SEP 21 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7996

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

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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:
St. Luke's Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether
In this community 38 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17 15
(If outside city or town limits, write "RURAL")

(d) Street No. 3910 Kingsland Court 9
(If rural, give location)

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

If yes, name country ------

3. (a) PRINT FULL NAME Mrs. Minnie Korst

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 Married/

6. (b) Name of husband or wife Hans C. Korst

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased January (Month) 4, (Day) 1886 (Year)

8. AGE: Years 59 Months 8 Days 7 If less than one day ___ hr. ___ min.

9. Birthplace Detroit, (City, town, or county) Michigan / (State or foreign country)

10. Usual occupation At Home

11. Industry or business ------

FATHER
12. Name William Miller
13. Birthplace (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name Elizabeth Dorr
15. Birthplace Detroit, (City, town, or county) Michigan / (State or foreign country)

16. (a) Informant Mr. Hans C. Korst
(b) Address 3910 Kingsland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/45 (Month) (Day) (Year)
(c) Place: burial or cremation Lake Charles Burial Park

18. (a) Signature of funeral director Beiderwieden F. H., Inc.
(b) Address 1936 St. Louis Ave.

19. (a) SEP 13 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 11, year 1945 hour 2: minute 15 A. M.

21. I hereby certify that I attended the deceased ~~from~~ on 9/10/45, 19__, to ___, 19__; that I last saw her alive on 9/10/45, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Bleeding into brain

Due to Rupture of cerebral artery spontaneous

Due to

Other conditions 83 1
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Bleeding into brain rupture into subarachnoid space

Duration

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 Andrew B. Jones (M. D. or other)

Address 3720 Washington Date signed 9/11/45

(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 Glen W. Hart

Licensed Embalmer No. 3737

P. O. Address 1936 St. Louis 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.