

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

State File No. **34645**
Registrar's No. **2473**

FILED NOV 3 1945

Registration District No. **317**

Primary Registration District No. **2002**

1. PLACE OF DEATH:

(a) County **ST. Louis Co. Mo.**
(b) City or town **University City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Christian's Old Peoples Home**
(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 **Mo.** (b) County **St. Louis Co. Mo.**
(c) City or town **St. Louis Mo. City**
(If outside city or town limits, write "RURAL")
(d) Street No. **6600 Washington**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **CHARLES F. Kuhlentreck**
3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **FEB 19 1873**
(Month) (Day) (Year)

8. AGE: Years **72** Months **8** Days **7** If less than one day _____ hr. _____ min.

9. Birthplace **Collinsville** (City, town, or county) **Ill.** (State or foreign country)

10. Usual occupation **Salesman**

11. Industry or business **Retired**

12. Name **John Kuhlentreck**

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

14. Maiden name **Christine Lange**

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

16. (a) Informant **Chas Kuhlentreck, Jr.**

(b) Address **4850 Northland**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Oct 29 1945**
(Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **Provost and Co**

(b) Address **3710 97th Grand Blvd.**
19. (a) **OCT 28 1945** (Date received local registrar) (b) **E. J. M. Gavan** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **26** year **1945** hour **11** minute **10 a. M.**
21. I hereby certify that I attended the deceased from **8-2-45** to **Oct 26 -** 19**45**;
that I last saw him alive on **Oct 26 -** 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death **Acute nephritis** Duration **1 wk**
Due to **130**
Due to _____

Other conditions **Paralysis agitans**
(Include pregnancy within 3 months of death)

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) _____
(e) Means of injury _____
23. Signature **W. J. Ryan** (M. D. or other) _____
Address **607 N. Grand St.** Date signed **10.27.45**

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

MOTHER FATHER

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.....

Carl P. Probst

Licensed Embalmer No..... *1578*

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.