

S. No. 2
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7-5-17-39
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35413

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 9765

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 days
(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. 3710 French
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME KATE HORACK
3. (b) If veteran, name war None
3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month November day 8
year 1945 hour 2:53 minute P M.
21. I hereby certify that I attended the deceased from October 18, 1945, to November 8, 1945;
that I last saw her alive on November 8, 1945;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Frank Horack 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 6, 1892
(Month) (Day) (Year)

Immediate cause of death Stomach - carcinoma of gall-bladder Duration 3 mos.
Due to hepato-renal syndrome
Due to _____

8. AGE: Years Months Days If less than one day
53 3 2 _____ hr. _____ min.

Other conditions Hepato-renal syndrome
(Include pregnancy within 6 months of death)

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

10. Usual occupation Matron

11. Industry or business Cleveland High School

12. Name August Krah

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

14. Maiden name Anna Menrhtens

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

16. (a) Informant Mrs. Minnie Allison
(b) Address 3850a Wyoming

17. (a) Burial (b) Date thereof 11-12-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New Picker Cemetery

18. (a) Signature of funeral director Southern Funeral Home
(b) Address 6322 S. GRAND BLVD

19. (a) NOV 11 1945 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

Major findings: Of operations Same
Of autopsy same
PHYSICIAN [Signature]
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 Mr. Kora (M. D. or other)
Address 1545 Lafayette Avenue Date signed 11/8/45

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 W. G. Peterson

Licensed Embalmer No. 3167

P. O. Address Overland Park 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.