

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

35517

FILED DEC 31 1945
318

State File No. _____

Registration District No. _____ Primary Registration District No. _____

1003

Registrar's No. 10298

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:
4504a Clayton Ave /
(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 Jennie Kuehl
3. (b) If veteran, name war None
3. (c) Social Security No. 4 200

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: March 29, 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 7 28 _____ hr. _____ min.

9. Birthplace Bunker Hill Ill. /
(City, town, or county) (State or foreign country)

10. Usual occupation Office Manager

11. Industry or business Daisy Churn Co.

MOTHER FATHER

12. Name William Kuehl

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

14. Maiden name Sophie Hince

15. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Otto Kuehl

(b) Address 4504a Clayton Ave

17. (a) Burial (b) Date thereof 11/29/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) NOV 28 1945 (b) J. F. Brodbeck
(Date received local registrar) (Registrar's signature)

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. 4497 Pershing
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26,
year 1945 hour 2:30 PM minute _____ M.
21. I hereby certify that I attended the deceased from Nov 15, 1945
19 _____, to Nov 27 19 45
that I last saw her alive on Nov 17 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach
Duration 6 months

Due to _____

Due to _____

Other conditions: _____
(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? _____

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

23. Signature Bert W. Klein (M. D. or other) M.D.

Address 7637 S Kingshighway Date signed 11-27-45

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

20
17
9

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 *Gustav W. Dietrich*

Licensed Embalmer No. *4329*

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.