

S. No. 2
 DM-542
 Rev. 5-17-39
 X32873

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **38532**
 Registrar's No. **2713**

FILED DEC 17 1945

Registration District No. **277** Primary Registration District No. **6076**

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

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Manchester
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Manchester Nursing Home 4
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 Months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town Lemay
(If outside city or town limits, write "RURAL")
 (d) Street No. 2235 Telegraph Road
(If rural, give location)
 (e) Citizen of foreign country? No
 If yes, name country _____

3. (a) PRINT FULL NAME Lena Kohr
3. (b) If veteran, name war *****
3. (c) Social Security No. *****

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 26th day November
 year 1945 hour 8:00 minute P. M.

4. Sex Female **5. Color or race** White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Frank Kohr **6. (c) Age of husband or wife if alive** 82 years
7. Birth date of deceased April 4 1868
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 21
1915 to Nov 26 1945
 that I last saw her alive on Nov 26 1945
 and that death occurred on the date and hour stated above.
 Immediate cause of death Senility **Duration** _____

8. AGE: Years Months Days If less than one day
77 7 22 0 hr. min.

Due to generalized arteriosclerosis
 Due to 1624
 Other conditions Senility
(Include pregnancy within 3 months of death)

9. Birthplace Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation At Home

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name John Heidal
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Iredanz
15. Birthplace Germany
(City, town, or county) (State or foreign country)
16. (a) Informant Frank Kohr
(b) Address 2235 Telegraph Road Lemay Mo
17. (a) Burial Burial **(b) Date thereof** Nov 29th 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cemetery
18. (a) Signature of funeral director Frederick Bros.
(b) Address 6408 Gravois Ave
19. (a) 4-30-45 **(b) C. P. N. Gorman M.D.**
(Date received local registrar) (Registrar's signature)

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 A. L. Murlin M.P. (M. D. _____)
 Address 3507 Poloma Date signed 11-24-45

Dr. M. M. M. M.
3507 Potomac St
202-1863

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 Rex E. Campbell
Licensed Embalmer No. 5881
P. O. Address W. Davis, Md.

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.