

No. 2
1-5-43
5-17-39
I X 36671

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **434**

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. Anthony's Hospital
(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 Life (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME Anna Kuehne

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Ernst 6. (c) Age of husband or wife if alive years
7. Birth date of deceased 9 5 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 4 8 _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name George Schuster
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Barbara Kornberger
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Ernst Kuehne, Jr.
(b) Address 4253 Iowa, St. Louis Missouri

17. (a) Burial (b) Date thereof JAN. 16-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (c) Signature of funeral director C. HOEFMEISTER COLONIAL MORTUARY

(b) Address 6464 Chippewa, St. Louis, Missouri

19. (a) JAN 15 1946 J. F. Bredeck
(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. 4253 Iowa (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 13
year 1946 hour _____ minute 3:10 AM

21. I hereby certify that I attended the deceased from 6-10, 1946, to death, 13, 1946
that I last saw her alive on 1-12, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 36 hrs.

Due to arteriosclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) glt

Major findings: Of operations _____ Of autopsy _____

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 John J. Burk (M. D. or other) M.D.
Address 3115 S. Grand Date signed 1-14-46

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

2743

Dr. F J Burke
3115 S Broadway

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 *Linus C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadway*

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.