

S. No. 2
M-5-43
7-5-17-39
X36671

FILED FEB 19 1946
Registration District No. **318**

Primary Registration District No. **100**

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

1. PLACE OF DEATH:

(a) County St. Louis Mo

(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3539 Halliday Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Clara Koora

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female **5. Color or race** White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Bernard

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 7 1861
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>3</u>	<u>24</u>	hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business at Home

MOTHER FATHER

12. Name Herman Mueller

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

14. Maiden name Mary Richter

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

16. (a) Informant George B Koors

(b) Address 3539 Halliday

17. (a) Burial (b) Date thereof 2 4 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser

(b) Address 4228 So. Kingshighway

19. (a) FEB 3 1946 (b) J. F. Brueck
(Date received local registrar) (Embalmer's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 16/17

(d) Street No. 3539 Halliday Ave
(If rural, give location) 90

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 1
year 1946 hour 12.40 PM 1 M.

21. I hereby certify that I attended the deceased from May 15 1945 to Feb 1 1946
that I last saw her alive on Feb 1 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Ch. myocardi. **Duration** _____

Due to _____

Due to _____

Other conditions General Arterial Sclerosis
(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 Wm. R. Nye (M. D. or other) Om. D.

Address 2931 Erwood av **Date signed** 2/4/46

Dr Nye

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

Chas. D. Mc Dermott

Licensed Embalmer No.

3024

P. O. Address _____

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.