

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10634**
Registrar's No. **685**

FILED APR 1 1946
Registration District No. **3066**

Primary Registration District No. **3066**

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

1. PLACE OF DEATH:

(a) County **St Louis**
(b) City or town **Kirkwood**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
404 W. Rose Hill 1
(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 **Charles H. Neuhaus**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Sarah Kuyon** 6. (c) Age of husband or wife if alive **66** years
7. Birth date of deceased **Feb 15 - 1879**
(Month) (Day) (Year)

8. AGE: Years **67** Months **1** Days **5** If less than one day _____ hr. _____ min.

9. Birthplace **Nashville** (City, town, or county); **Tenn** (State or foreign country)

10. Usual occupation **Salesman**

11. Industry or business **Service Station**

MOTHER FATHER { 12. Name **Charles S. Neuhaus**
13. Birthplace **St Charles Co Mo** (City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Deibel**
15. Birthplace **Nashville** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Charles H Neuhaus**

(b) Address **404 W. Rose Hill**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **3-23-46** (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Hill Cem**

18. (a) Signature of funeral director **Louis H. Bopp Sr**

(b) Address **Kirkwood Mo**

19. (a) **3-23-46** (Date received local registrar) (b) **W. Walter Brown** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St Louis**
(c) City or town **Kirkwood**
(If outside city or town limits, write "RURAL")
(d) Street No. **404 W. Rose Hill** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **20** year **1946** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **1942** to **March 29** 19**46** that I last saw him alive on **March - 1946** and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Prostate 3 yrs**

Due to _____
Due to **51/5**

Other conditions (Include pregnancy within 3 months of death)

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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature **W. Walter Brown** (M. D. or other) Address **W. Walter Brown** Date signed **4/4/46**

Duration
Physician
Underline the cause to which death should be charged statistically.

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..... *Felix Hurand*

Licensed Embalmer No..... *3034*

P. O. Address..... *Kirkwood 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.