

**FILED** MAR 27 1946  
318

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2620**

**1. PLACE OF DEATH:**  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4101 North Broadway  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Edward C. Kohrumel  
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 Edna Anna Kohrumel nee Frazee (c) Age of husband or wife if alive 77 years  
7. Birth date of deceased March 8, 1863  
(Month) (Day) (Year)

8. AGE: Years 83 Months 0 Days 9 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Druggist  
Retired

11. Industry or business \_\_\_\_\_  
12. Name Louis Kohrumel  
13. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Ann Beehler  
15. Birthplace St. Charles Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Edna Anna Kohrumel  
(b) Address 4101 N. Broadway  
17. (a) Burial (b) Date thereof 3/20/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math Hermann & Son  
(b) Address 2161 East Fair Ave

19. (a) MAR 19 1946 (Date received local registrar) J. F. Bredek (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County 000  
(c) City or town St. Louis 9 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4101 North Broadway 9  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 17th  
year 1946 hour 1:45 PM. minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from 3/11 1946, to 3/17 1946  
that I last saw him alive on 3/17/46 and that death occurred on the date and hour stated above.

Immediate cause of death Asphyx Duration 3-4  
Due to Respiration 1-42  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
\* (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
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 [Signature] (M. D. or other) \_\_\_\_\_  
Address 4901 N. Broadway Date signed 3/19/46

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**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 *William G. Burkholder*

Licensed Embalmer No. *2110*

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 2620

Registration District No. 318

Primary Registration District No. 1003

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:  
  
(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 Eduard C. Kehrume

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased May (Month) 8 (Day) 1946 (Year)

8. AGE: Years 83 Months Days If less than one day  
.....hr. ....min.

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

10. Usual occupation.....  
11. Industry or business.....

MOTHER FATHER { 12. Name.....  
13. Birthplace..... (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....  
(b) Address.....  
17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....  
19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 7  
Year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....;  
that I last saw him..... alive on....., 19.....;  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration.....  
Due to.....  
Due to.....  
Jealousy of Kehrume

Other conditions..... (Include pregnancy within 3 months of death)  
Major findings:  
Of operations.....  
Of autopsy..... 1316

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

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..... (M. D. or other).....  
Address..... Date signed.....

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

10072

11330.