

FILED APR 24 1948
318

State File No.

Registration District No.

Primary Registration District No. 1003

Registrar's No. 3616

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

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:
Deaconess Hospital - 6150 Oakland
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 weeks
(Specify whether years, months or days)

In this community.....

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. 6534 Berthold
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME KESSLER - ALMA M.

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Albert D. Kessler

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Aug 16 1899
(Month) (Day) (Year)

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

46 8 1 hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name Adam Mueller

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

14. Maiden name Genevieve Goehns

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

16. (a) Informant Albert D. Kessler

(b) Address 6534 Berthold

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

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Walter Center Mortuary

(b) Address 4024 Lindell Blvd.

19. (a) APR 19 1948 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 17 year 1946 hour 9 minute AM

21. I hereby certify that I attended the deceased from 4/4 to April 17 1946 that I last saw her alive on 4/17 and that death occurred on the date and hour stated above.

Immediate cause of death. General carcinoma about sigmoid of S
Duration 3 years

Due to.....

Due to.....

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

Major findings: Abdominal section

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) Means of injury.....

23. Signature [Signature] (M. D. or other) Address 315 So Grand St Date signed 4/18/46

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 Rev. E. Campbell
Licensed Embalmer No. 3881

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.