

#25882

FILED MAY 31 1946

Registration District No. 318

Primary Registration District No. 1003

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. Louis City Hospital-Max C. Starkloff
(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)

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. 1003 Park Avenue
Memorial (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SUSIE KIEL

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 Widow
6. (b) Name of husband or wife William Kiel 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 8, 1874
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name John Oehler
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Susie Koenig
(b) Address 4408 Chouteau Avenue
17. (a) Burial (b) Date thereof 5-22-1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Wm L. Engel
(b) Address 1926 Allen Avenue
19. (a) MAY 22 1946 (b) J. F. Brueck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19th
year 1946 hour 5:00 minute _____ P. M.
21. I hereby certify that I attended the deceased from 2/18/46
_____ 19 _____ to 5/19/46 _____ 19 _____
that I last saw him alive on 5/19/46 _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: None
Of operations _____
Of autopsy Hypertrophy + dilatation of the heart
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 John Brown (M. D. or other) _____
Address City Hosp Date signed _____

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

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.....

Licensed Embalmer No. 4053

P. O. Address Louis Ia.

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.