

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21934

State File No.

FILED JUL 3 1946
318

1003

Registrar's No. 5519

Registration District No. Primary Registration District No.

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: Shrout City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____

In this community 48 Yrs 5 Mons 12 Days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Marie M. Kuse

3. (b) If veteran, name war _____

3. (c) Social Security No. 492-22-8815

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Wm C. Kuse

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased 1 7 1898
(Month) (Day) (Year)

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

48	5	12	hr. min.
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9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

MOTHER FATHER

11. Industry or business _____

12. Name Frank S. Kessler

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

14. Maiden name Rose Herzog

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

16. (a) Informant Wm C Kuse

(b) Address 1441 E Gano

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-46
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Woodhart & Grodhat

(b) Address 2228 St. Louis Ave

19. (a) JUN 24 1946 (Date received local registrar) J. F. Bredek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 900

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

(d) Street No. 1441 E Gano
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 19
year 1946 hour 9 minute 15 a.m.

21. I hereby certify that I attended the deceased from _____, 19____, 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 Acute Vegetative Exhaustion

Due to and Widespread Regurgitation

Due to _____

Other conditions (Include pregnancy within 3 months of death) 92

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

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? _____

23. Signature Patric E Taylor Sep 21 1946
(Specify type of place) (Means of injury) (City or town) (County) (State)

Address 1300 Clark Date signed 6-21-46

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

20813

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

Marie A. Cashion

Licensed Embalmer No.

3949

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.