

U.S. No. 2  
FORM-5-43  
REV. 5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **25436**  
Registrar's No. **6603**

**FILED** **808 5 1946**

Primary Registration District No. **1003**

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

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: Firmin DesLoge Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day  
(Specify whether \_\_\_\_\_)

In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 2x/1/9

(d) Street No 2931 IOWA  
(If rural, give location)

(e) Citizen of foreign country? ---- (Yes or No) 0

If yes, name country ----

3. (a) PRINT FULL NAME ALBERT KOBERMANN

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 Helen Kobermann

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased June 18, 1889  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26  
year 1946 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 25  
1946, to July 26 1946  
that I last saw h. i. m. alive on July 25 1946  
and that death occurred on the date and hour stated above.

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

57 I 8 hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral hemorrhage 1 d.

Due to Hypertension 220/120 ?

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

10. Usual occupation Nil

11. Industry or business Nil

12. Name William K. Kobermann

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

14. Maiden name Marie Loecke

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Helen Kobermann

(b) Address 2931 IOWA

17. (a) Burial (b) Date buried July 29, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter & Paul Cemetery

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.

(b) Address 7814 S. Broadway

19. (a) Jul 29 1946 (Date received from registrar)

J. F. Bredeck (Registrar's signature)

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 Amos C. Reed (M. D. or other) 2nd

Address 5200 Chippewa Date signed 7-27-46

5203 Disposition  
2-3 p.m.  
7-8 p.m.

**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..... *James A. Hoffmann* .....

Licensed Embalmer No. *3871* .....

P. O. Address..... *7814 S. Broadway* .....

**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.