No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 1 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15296

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4177

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: DePaul Hospital O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 6 7
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4919 Maffit Place 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country --

3. (a) PRINT FULL NAME John Henry Kohler

3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Male O
5. Color or race White
6. (a) Single, widowed, married, divorced Single O
6. (b) Name of husband or wife Single
6. (c) Age of husband or wife if alive Single years
7. Birth date of deceased December 27, 1930 (Month) (Day) (Year)

8. AGE: Years 16 Months 3 Days 23 If less than one day hr. min.

9. Birthplace St. Louis, Missouri O (City, town, or county) (State or foreign country)
10. Usual occupation School boy
11. Industry or business

FATHER
12. Name Dr. Eugene J. Kohler O
13. Birthplace St. Louis, Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Cecelia Ryan
15. Birthplace Washington D. C. 1 (City, town, or county) (State or foreign country)

16. (a) Informant Dr. Eugene J. Kohler
(b) Address 4919 Maffit Place
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 23 '47 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Bromschwig and Son Funeral Home
(b) Address 4746 W. Florissant Ave.
19. (a) APR 22 1947 (Date received local registrar) (b) J. F. Brabeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20th year 1947 hour 8 minute a M.

21. I hereby certify that I attended the deceased from March 1, 1947, to April 20th, 1947 that I last saw him alive on April 19th, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Left vent. failure — Duration 24 hrs.
Due to Hypertension + Uremia — Several Years.
Due to Glomerulonephritis.
Other conditions (Include pregnancy within 3 months of death)
Major findings: 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? (Specify type of place)
While at work? (e) Means of injury O

23. Signature D. B. Flavan (M. D. or other) MD
Address Humboldt Bldg. St. Louis Date signed 4/22/47

(Licensed Embalmer's Statement on Reverse Side)

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 G. W. Wilkinson

Licensed Embalmer No. 3575

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.