

S. No. 2
OM-8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15957
State File No. _____
Registrar's No. 973

FILED MAY 8 1947

Registration District No. 37

Primary Registration District No. 4465

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Rock Hill
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
9727 Mueck Terrace
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Charles K. Karner
(b) If veteran, name war _____
(c) Social Security No. 488-10-8455

4. Sex M race W
5. Color or race W
6. (a) Single, widowed, married, divorced married
(b) Name of husband or wife Theresa nee Joseph
(c) Age of husband or wife if alive 70 years
7. Birth date of deceased Nov. 11 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 5 15 hr. _____ min.

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

10. Usual occupation Sausage Maker

11. Industry or business _____

MOTHER FATHER
12. Name Karl Karner
13. Birthplace Unknown Austria
(City, town, or county) (State or foreign country)
14. Maiden name Maria Graf
15. Birthplace Unknown Austria
(City, town, or county) (State or foreign country)

16. (a) Informant Theresa Karner
(b) Address 9727 Mueck Terrace

17. (a) Burial (b) Date thereof Apr. 29, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus

18. (c) Signature of funeral director Jay B. Smith
(b) Address 7456 Manchester

19. (a) 5-1-47 (b) Paul C. Sharpe MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis 96
(c) City or town Rock Hill 14
(If outside city or town limits, write "RURAL")
(d) Street No. 9727 Mueck Terrace 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26
year 1947 hour 5 minute 30 P.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 Pulmonary embolus
Duration Immediate

Due to Chronic Myocarditis with Myocardial degeneration 2 years
Due to gnd

Other conditions none
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations none
Of autopsy none
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) (c) Means of injury _____

23. Signature P. L. McCall (M. D. or other) M.D.
Address 9012 Manchester Date signed _____

179! / 7M

OF
IS

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 3454

....., Registered Apprentice No.
working under my personal supervision.

Signed David C. Libean

Licensed Embalmer No. 3454

P. O. Address 7456 Grand Ave

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.