. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 8 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 25740 7196

Registrar's No.

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

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: 1114 Buchanan St. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0-00

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 26 1114 Buchanan St. 9
(If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME Augusta Kobielski

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Frank Kobielski

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

7. Birth date of deceased July 25, 1862
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
85	0	6	hr. min.

9. Birthplace Unknown Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business

FATHER
12. Name William Zart
13. Birthplace Unknown Germany 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Vent
15. Birthplace Unknown Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph W. Cook
(b) Address 1114 Buchanan St.

17. (a) Burial (b) Date thereof 8/4/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math Hermann & Son, Inc.
(b) Address 2161 East Fair Ave

19. (a) AUG 2 19 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 1,
year 1947 hour 1:00 AM minute M.

21. I hereby certify that I attended the deceased from May 3 1940 to Aug 1 1947
that I last saw her alive on July 31 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Cause Cerebrosis of liver

Due to Old age

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration
7 yrs
17 yrs

PHYSICIAN

Underline the cause of 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 0

23. Signature J. C. Creane (M. D. or other) M.D.
Address 2504 N 14th St. Date signed 8-1-47

Jefferson City Printing Co.

(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 William E Burchhof

Licensed Embalmer No. 2140

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.