

Registration District No. **317**

Primary Registration District No. **3063**

Registrar's No. **2309**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **Clayton**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **St. Louis County Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10 days**
(Specify whether)

In this community **85 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **Kirkwood**
(If outside city or town limits, write "RURAL")

(d) Street No. **711 S. Kirkwood Rd.**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Augusta Kohlbrly**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **3**
year **1947** hour **12** minute **45 a.** M.

4. Sex **Female** 5. Color or race **White**

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **Oct. 13 1862**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan 1** 19**47** to **November 1** 19**47** that I last saw her alive on **10-26** 19**47** and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	85	0	20	hr. _____ min _____

Immediate cause of death **Acute cardiac dilatation** Duration **10 day**

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

Due to **Chronic myocarditis**

10. Usual occupation **Retired**

Due to **93**

Other conditions **Senile dementia**
(Include pregnancy within 3 months of death)

11. Industry or business _____

12. Name **Carl Kohlbrly**

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

14. Maiden name **Unknown**

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause of which death should be charged statistically.

16. (a) Informant **Miss Nadine Brown (Matron)**

(b) Address **Kirkwood Old Folks Home**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

17. (a) **Burial** (b) Date thereof **11/4/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ **Bellefontaine**

(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)

18. (a) Signature of funeral director **Louis H. Bopp, Inc.**

(b) Address **131 W. Argonne Dr. Kirkwood**

While at work? _____ (Specify type of place)

Means of injury _____

23. Signature **R. A. Hesler** (M. D. or other) **MD**

19. (a) **11-3-47** (b) **Cecil A. Sharpe**
(Date received local registrar) (Registrar's signature)

Address **Kirkwood, Mo** Date signed **11/3/47**

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

MOTHER FATHER

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 Felix Durand

Licensed Embalmer No. 3034

P. O. Address Brookwood 22 me

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.