

S. No. 2  
12-45  
17-39  
K47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36536**  
Registrar's No. **2282**

FILED NOV 14 1947

Registration District No. **377** Primary Registration District No. **3069**

1. PLACE OF DEATH:  
(a) County **St. Louis, Richmond Mo**  
(b) City or town **Richmond Mo**  
(c) Name of hospital or institution **St. Mary's Hospital. 0**  
(d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Lillian Kuhlmann.**  
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Jan. 23, 1884.**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**67 9 10** hr. min.

9. Birthplace **Bellville Ill.** (City, town, or county) (State or foreign country)  
10. Usual occupation **Housework**

11. Industry or business **William Sergeant.**

12. Name **England** 4  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Nicholson**  
15. Birthplace **Bellville Ill.** (City, town, or county) (State or foreign country)

16. (a) Informant **Walter Kuhlmann**  
(b) Address **5143 Wabada Ave.**  
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Nov. 6, 1947** (Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary Cemetery.**

18. (a) Signature of funeral director **J. Quinn**  
(b) Address **1389 Union Blv'd**

19. (a) **NOV 5 1947** (Date received local registrar) (b) **Walter Kuhlmann** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **000**  
(c) City or town **St. Louis, Mo.** (If outside city or town limits, write "RURAL")  
(d) Street No. **5143 Wabada Ave.** (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov 3** day \_\_\_\_\_ year **1947** hour **9** minute \_\_\_\_\_ P.M.  
21. I hereby certify that I attended the deceased from **October 26,** 19**45** to **November 3,** 19**47;** that I last saw her alive on **November 3,** 19**47** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary disease with occlusion.** Duration \_\_\_\_\_  
Due to **Hypertension**  
Due to **Arthritis** 99  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations **NO.** Of autopsy **NO.** 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) **NO.**  
(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) \_\_\_\_\_  
23. Signature **James J. Anderson** (At. D. or other) Address **634 North Grand** Date signed **11/5/47**

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

NOV 20 1947

NOV 28 1947

LHSL - 07

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 Ray Campbell  
Licensed Embalmer No. 3881

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.