No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 15 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 39855

Registrar's No. 11053

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: Josephine Heitkamp Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether

In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oao

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

(d) Street No. 1828a S.Broadway 9
(If rural, give location)

(e) Citizen of foreign country? 23 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Minnie Kottemann

3. (b) If veteran, name war -- | 3. (c) Social Security No. --

4. Sex Female 1 | 5. Color or race White | 6. (a) Single, widowed, married, divorced Single 0

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

7. Birth date of deceased January (Month) 1 (Day) 1864 (Year)

8. AGE: Years 83 | Months 11 | Days 0 | If less than one day hr. min.

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

10. Usual occupation Home 1

11. Industry or business

FATHER
12. Name Frederick Kottemann 4
13. Birthplace Unknown (City, town, or county) Germany 1 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown 9 (State or foreign country)

16. (a) Informant Emil Mecklenburg
(b) Address 8111 Roxburgh Dr., Clayton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/47 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cem.

18. (a) Signature of funeral director Wacker-Helderle
(b) Address 3634 Gravois Ave.

19. (a) DEC 2-1947 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 1 year 1947 hour 12 minute 46 A. M.

21. I hereby certify that I attended the deceased from 11.26-47, 19, to 11.30.47, 19 that I last saw her alive on 11-30, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia 2 days
Myocarditis Chronic

Due to

Due to

Other conditions —
(Include pregnancy within 3 months of death)

Major findings:
Of operations —

Of autopsy —

Duration

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 Philip Schuck (M. D. or other)

Address 1703 S Grand Date signed 12.1.47

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.....

Licensed Embalmer No. 2645

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.