

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21044**

FILED JUL 15 1948

Registration District No. **318**

Primary Registration District No. **10003**

Registrar's No. **3894**

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:
St. Johns Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 WEEK**
In this community **3 WEEK**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St Louis** (If outside city or town limits, write "RURAL") **17**
(d) Street No. **1107 CANAAN AVE.** (If rural, give location) **9**
(e) Citizen of foreign country? (Yes or No) **0**
If yes, name country.

3. (a) PRINT FULL NAME **MARIE KOLLER**
(b) If veteran, name war.....
(c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **JUNE** day **29**
year **1948** hour **9:00** minute **A** M.
21. I hereby certify that I attended the deceased from **1-4-48** to **6-29-48**
that I last saw her alive on **6-29-48**
and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **JOHN KOLLER**
6. (c) Age of husband or wife if alive **18** years **1888** (Year)

Immediate cause of death **Cerebral thrombosis**
Due to.....
Due to **Ch of Heart**
Other conditions (Include pregnancy within 3 months of death) **None**
Major findings: Of operations.....
Of autopsy.....

8. AGE: Years **59** Months **7** Days **11**
If less than one day hr. min. **4**

9. Birthplace **AUSTRIA** (City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business.....

MOTHER FATHER
12. Name **CARL SAMPL** #
13. Birthplace **AUSTRIA** (City, town, or county) (State or foreign country)
14. Maiden name **Agnes MITZ**
15. Birthplace **AUSTRIA** (City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.
Ch of Heart

16. (a) Informant **Mrs Schneider**
(b) Address **High Ridge Mo.**

17. (a) **BURIAL** (b) Date thereof **JULY 2 - 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

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?.....

(c) Place: burial or cremation **SALVARY SEMETARY**
18. (a) Signature of funeral director **Diedrich F. Howe**
(b) Address **JUL 18 1948 18316 Hager Ferry Rd.**
19. (a) **JUL 18 1948** (b) **J. F. Brumack**
(Date received local registrar) (Registrar's signature)

23. Signature **Carl Kessler** (M. D. or other) **6-30-48**
Address **Antwerp, Mo.** Date signed

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

John S. Dennis

Licensed Embalmer No. *4192*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.