

MISSOURI DIVISION OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

State File No. **21056**  
Registrar's No. **5943**

Registration District No. **318**

Primary Registration District No. \_\_\_\_\_

**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:  
2017 East Obear  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 48 years (Specify whether  
years, months or days)

3: (a) PRINT FULL NAME Edward G. Kueck

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Rose Strathmann 6. (c) Age of husband or wife if alive 65 years  
7. Birth date of deceased September 26, 1878  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
69 9 5 hr. min.

9. Birthplace Concordia, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Maintenance Man

11. Industry or business Candy Manufacturing

12. Name Henry Kueck

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Rose Kueck

(b) Address 2017 E. Obear

17. (a) Burial (b) Date thereof July 3, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem Cemetery

18. (a) Signature of funeral director Beiderwieden F. H., Inc.

(b) Address 1936 St. Louis Avenue

19. (a) JUL 3 1948 (b) J. J. Madach  
(Date received local health officer) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2017 East Obear  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 1  
year 1948 hour 5: minute 00 A. M.

21. I hereby certify that I attended the deceased from April 11, 1948  
to June 30, 1948  
that I last saw her alive on June 30, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Embolus  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Cerebral Sclerosis  
(include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_

(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)  
(c) Means of injury \_\_\_\_\_

23. Signature C. J. [Signature] (M. D. or other) \_\_\_\_\_

Address 4442 [Address] Date signed \_\_\_\_\_

Dr. A. F. Sternf  
4142 North Grand  
8-10:00 A.M.

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**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 *Paul H. Paulson*

Licensed Embalmer No. *4114*

P. O. Address *1936 St Louis Ave*

**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.**