

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED SEP 13 1948
Registration District No. **318**

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. **1003**

27896
State File No. _____
Registrar's No. **7605**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **3927 Russell**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **20 yrs.** (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **LUDWIG KERN**

3. (b) If veteran,
name war _____

3. (c) Social Security No. **495-28-6984**

4. Sex **Male** 5. Color **white** 6. (a) Single, widowed, married, divorced **widowed**
7. Birth date of deceased **June 25 1862**
(Month) (Day) (Year)

8. AGE: Years **86** Months **2** Days **4** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Chemist - retired**

11. Industry or business _____

12. Name **Emanuel Kern**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Bertha Baer**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Fernando Kern**
(b) Address **4339 Olive**
17. (a) **Burial** (b) Date thereof **8/31/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **B'nai Amoona Berger Memorial**
18. (a) Signature of funeral director **4715 McPherson**
(b) Address **AUG 30 1948**
19. (a) **J. F. Mueck** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3927 Russell**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **29**
year **1948** hour **12** minute **30** P.A.M.

21. I hereby certify that I attended the deceased from **Nov. 5,** 19 **45** to **Aug. 29,** 19 **48**
that I last saw him alive on **Aug. 29,** 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Myocarditis** Duration **5 days**

Due to **Chronic Interstitial Nephritis 3 yrs.**

Due to _____

Other conditions **1/2/1**
(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) (b) Means of injury _____

23. Signature **John F. Mueck** (M. D. or N. D.)
Address **508 N. Grand Blvd.** **8/30/48**

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.....

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.