

FILED NOV 24 1948 318

Registration District No.

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County..... City St Louis Mo.
(b) City or town..... City St Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Infirmiry Hospital .
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4-27-45 / 11-14
48
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Lea Kohler

3. (b) If veteran,
name war.....

3. (c) Social Security No.

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, 2 divorced widowed
(b) Name of husband or wife Louis 6. (c) Age of husband or wife if
alive..... years

7. Birth date of deceased..... Dec 16 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 10 28 hr. min.

9. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business.....

12. Name Frederich Wilhelms

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

14. Maiden name Engelhardt

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

16. (a) Informant Emma Boll

(b) Address 421 Burns Kirkwood

17. (a) Burial (b) Date thereof 11/17/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director John L Ziegenhein & Sons

(b) Address 7027 Gravois Ave.

19. (a) NOV 16 1948 (b) J. B. Passter
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County..... 17
(c) City or town..... St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 13 City Infirmiry
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11- day 14
year 1948 hour 10 minute 00P. M.

21. I hereby certify that I attended the deceased from
July 7, 1948, 1948 to 11-14, 1948
that I last saw her alive on 11-14-, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration

Arteriosclerotic Heart Disease

Due to.....

Due to.....

Other conditions Decubiti Hypostatic Pneumonia
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy same

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)

(e) Means of injury.....

23. Signature Cletis P. Kras, M.D. (M. D. or other)
Address 5600 Arsenal St. St. Louis Date signed Nov 13, 1948

JAN 25 1949

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 *W. G. Peterson*

Licensed Embalmer No. *3767*

P. O. Address *7027 Gravo*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. See
Registrar's No. 9920

Registration District No. 318

Primary Registration District No. 1003

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:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Lena Kohler
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased See 16
(Month) (Day) (Year)

8. AGE: Years 87 Months 16 Days mo
(If less than one day, hr. min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 _____ (M, D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

S-38336

H-2650