

300
10-47
7-39
3906

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

39002

State File No.

FILED DEC 4 1948

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 317

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 months
(Specify whether
In this community life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County — ood

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

(d) Street No. 2606 St. Louis Ave.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME Pohl, Benjamin Franklin

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex M 5. Color or race W

6. (a) Single, widowed, married married
divorced —

6. (b) Name of husband or wife Ida

6. (c) Age of husband or wife if alive 60(?) years

7. Birth date of deceased 4-18-84
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>64</u>	<u>7</u>	<u>6</u>	hr. <u>—</u> min. <u>—</u>

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

10. Usual occupation TAILOR

11. Industry or business —

12. Name Benjamin Franklin Pohl

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

14. Maiden name ANNA ELIZ. CARTER

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

16. (a) Informant Hospital Records

(b) Address Koch Hospitl, Koch, Mo.

17. (a) Cremation (b) Date thereof 11-27-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory.

18. (a) Signature of funeral director Goodhart & Goodhart

(b) Address 2228 St. Louis, Ave.

19. (a) 11-26-48 (b) Phured b. L...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 24
year 1948 hour 7 minute 35 P.M.

21. I hereby certify that I attended the deceased from 8-12-47
....., 19....., to 11-24-48, 19.....;

that I last saw h. in alive on 11-24-48, 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to 136

Due to —

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

Major findings:
Of operations —

Of autopsy Pulmonary Tuberculosis

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 —

Signature John Niederwimmer (M. D. or other) M.D.

Address Koch, Mo Date signed 11-25-48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1944 - 1945

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.....

Frank J. [Signature]
Licensed Embalmer No. *2675*
P. O. Address *[Signature]*

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.