

FILED MAY 18 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

17421

318

1003

4059

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <u>City</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>U</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis Mo.</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>3839 California Ave.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Madelin</u>		b. (Middle) <u>Clara</u>		c. (Last) <u>Kohl</u>	
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 4, 1949</u>	
9. AGE (In years last birthday) <u>60</u>		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo. ( )</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Thorwald Myhre</u>		13b. MOTHER'S MAIDEN NAME <u>Clara Brighton</u>		14. NAME OF HUSBAND OR WIFE <u>Andrew Kohl</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Andrew Kohl 3839 California</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral haemorrhage - left</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic fibrillation auricular</u> DUE TO (c) <u>Chronic myocarditis</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>2 yrs.</u> <u>4 yrs.</u> <u>10 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>930</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <u>11:23 AM</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>11:23 AM</u>			
22. I hereby certify that I attended the deceased from <u>Sept. 28, 1939</u> , to <u>May 4, 1949</u> , that I last saw the deceased alive on <u>May 4, 1949</u> , and that death occurred at <u>2 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W. S. Becke D. M. D.</u>				23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>5/5/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Fri May 6th</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>	
DATE REC'D BY LOCAL REG. <u>MAY 5 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. S. Becke &amp; Son, 6175 Delmar</u>			

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

Dr. Beebe  
Rumont 03  
Je 8498  
1:30 or after

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Joseph M. McElduff*

Licensed Embalmer No. 2460

P. O. Address 6175 Palms

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.