

No. 300
10. 48

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28251
7654
Registrar's No.

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) Saint Louis	c. LENGTH OF STAY (In this place) Life	c. CITY (If outside corporate limits, write RURAL and give township) Saint Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5832 Wise Ave		d. STREET ADDRESS (If rural, give location) 4 - 5832 Wise	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Joseph c. (Last) Kohler			4. DATE OF DEATH (Month) (Day) (Year) Sept. 2nd, 1949			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH March 8th, 1917	9. AGE (In years last birthday) 32	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer - Clerk		10b. KIND OF BUSINESS OR INDUSTRY Fly-Walker	11. BIRTHPLACE (State or foreign country) Saint Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME John Kohler	13b. MOTHER'S MAIDEN NAME Nellie Jones	14. NAME OF HUSBAND OR WIFE Single
-----------------------------------	---	---------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 492-12-8121	17. INFORMANT'S SIGNATURE OR NAME John Kohler	ADDRESS 5832 Wise Ave. St. Louis, Mo
---	--	--	---

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1943
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Tuberculous Enteritis		3 weeks	

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) 12 (Mo)
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 002X
--	--	------------------------------------

22. I hereby certify that I attended the deceased from Feb. 5, 1947, to Sept. 2, 1949, that I last saw the deceased alive on Sept. 1, 1949, and that death occurred at 6:30 Am., from the causes and on the date stated above.

23a. SIGNATURE a.g. Steiner	(Degree or title) M.D.	23b. ADDRESS 634 N. Grand, 3.	23c. DATE SIGNED 9-2-49
--------------------------------	---------------------------	----------------------------------	----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/5/49	24c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County Mo
---	---------------------	--	--

DATE REC'D BY LOCAL HEALTH DEPT. SEP 2	REGISTRAR'S SIGNATURE J.B. Lucite	25. FUNERAL DIRECTOR'S SIGNATURE Ambruster Mortuary	ADDRESS 6633 Clayton Rd
---	--------------------------------------	--	----------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

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

Signature

Ernest W. Spillers

Licensed Embalmer No. _____

4080

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.