

FILED SEP 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28253

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7206

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>000</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>1</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>12</u> <u>3</u>		d. STREET ADDRESS (If rural, give location) <u>16 4301 Potomac Str.</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Anthony Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>16 4301 Potomac Str.</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>Edna</u> b. (Middle) <u>Augusta</u> c. (Last) <u>Kolkhorst</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 4th 1949</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 26 1886</u>	9. AGE (In years last birthday) (Months) (Days) (Hours) (Mins.) <u>63</u> <u>1</u> <u>8</u>	10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>John H. Debrodt</u>	13b. MOTHER'S MAIDEN NAME <u>Mathilda Young</u>	14. NAME OF HUSBAND OR WIFE <u>F. Wm. Kolkhorst</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Olive Langsdorf</u>	ADDRESS <u>6443 Southwest av.</u>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arteriosclerosis heart disease and nephritis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>arteriosclerosis General</u> DUE TO (c) _____		MEDICAL CERTIFICATION <u>arteriosclerosis heart disease and nephritis</u> <u>arteriosclerosis General</u>	INTERVAL BETWEEN ONSET AND DEATH <u>unk</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>677</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>H2O</u>
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22. I hereby certify that I attended the deceased from July 1, 1949, to Sept 4, 1949, that I last saw the deceased alive on Sept 3, 1949, and that death occurred at 11 A. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert G. Warner MD</u>	(Degree or title)	23b. ADDRESS <u>Paul Berni Bed. St. Louis, Sept. 5, 49</u>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>9-7-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
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DATE REC'D BY LOCAL REG. <u>SEP 6 1949</u>	REGISTRAR'S SIGNATURE <u>J. B. Jasater</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Schumaeh</u>	ADDRESS <u>3013 Meramec</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Form B-106 E106

CH. 4747

5017 *Williamson*

6600 *meat*
4100 *meat*

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 *Francis Williamson*

Licensed Embalmer No. *3565*

P. O. Address *St. Louis, Mo.*

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.