

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31924
State File No. 8378
Registrar's No. 1003

318

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| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 8378 | |
| 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) St. Louis | | c. LENGTH OF STAY (In this place) _____ | | c. CITY (If outside corporate limits, write RURAL and give township) St. Louis | | M | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 5720 Roosevelt / | | | | d. STREET ADDRESS (If rural, give location) 5720 Roosevelt | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Lena | | b. (Middle) _____ | | c. (Last) Kumke | | 4. DATE OF DEATH (Month) (Day) (Year) Sept. 27, 1949 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH- Jan. 3, 1861 | |
| 9. AGE (In years last birthday) 88 | | IF UNDER 1 YEAR Months _____ | | IF UNDER 1 YEAR Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) Rima, Ill. / | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13a. FATHER'S NAME Henry Hachmeister | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Charles Kimke | | | |
| 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. None | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dora Loesche, 5720 Roosevelt | | | |
| 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) Cerebral apoplexy. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Vascular Disease. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH 334X | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 102 | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? H H H H | | | |
| 22. I hereby certify that I attended the deceased from 8/27, 1949, to 9/22, 1949, that I last saw the deceased alive on 9/26, 1949, and that death occurred at 3:50 a.m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) H. F. Bergman (M.D.) | | | | 23b. ADDRESS 3220 Washington | | 23c. DATE SIGNED 9/29/49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 9-28-49 | | 24c. NAME OF CEMETERY OR CREMATORY City | | 24d. LOCATION (City, town, or county) (State) Red Bud, Ill. | |
| DATE REC'D BY LOCAL REG. SEP 29 1949 | | REGISTRAR'S SIGNATURE J. B. Susater | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd. | | | |

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

8378

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 J. W. B. Embler

Licensed Embalmer No. 3653

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.