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FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42674

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 41111

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>680</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u> )	c. LENGTH OF STAY (in this place) <u>11</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Paul Hosp.</u>		d. STREET ADDRESS (If rural, give location) <u>5891 Wabada</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Frank</u>	b. (Middle) <u>J</u>	c. (Last) <u>Kohler</u>	4. DATE OF DEATH (Month) (Day) (Year)	<u>12</u> <u>21</u> <u>1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>3-11-1872</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>St. Louis D</u>	12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>
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13a. FATHER'S NAME <u>John Kohler</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Couch</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT'S SIGNATURE OR NAME <u>Harry Kohler</u>	ADDRESS <u>6424 Arsenal</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Decomposition</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocardial Disease</u> DUE TO (c) <u></u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	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)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis MO MO</u>
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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? <u>H2O</u>
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22. I hereby certify that I attended the deceased from Jan. 1947 to Dec. 1949, that I last saw the deceased alive on 19, and that death occurred at 11:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Paul B. Webb M.D.</u> (Degree or title)	23b. ADDRESS <u>1915 S. Sidney St.</u>	23c. DATE SIGNED <u>12/27/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>12-24-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>	24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
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DATE REC'D BY LOCAL REG. <u>DEC 23 1949</u>	REGISTRAR'S SIGNATURE <u>J. B. Foster</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>SULLIVAN-BROS</u>	ADDRESS <u>2849 N. EUCLID</u>
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(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

Signed *Robert L. Brinkman*

Licensed Embalmer No. *3553*

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.