

FILED JUL 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21709

State File No. 5523  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. <b>1003</b>		State File No. 5523 Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis</b> )		c. LENGTH OF STAY (in this place) <b>50 Yrs.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2159</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4215a California Ave.</b>				15. STREET ADDRESS (If rural, give location) <b>4215a California Ave.</b>			
3. NAME OF DECEASED (Type or Print) <b>Emma Louise Kohler</b>			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <b>June 22, 1950</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Sept. 8, 1879</b>	
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 18 YRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <b>Sandy, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13a. FATHER'S NAME <b>John Stahl</b>			13b. MOTHER'S MAIDEN NAME <b>Anna Rabe</b>			14. NAME OF HUSBAND OR WIFE <b>Charles H. Kohler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. _____			17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Walter Horstman, 4215a California Ave.</b>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> DUE TO (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>General Arteriosclerosis</b> II. OTHER SIGNIFICANT CONDITIONS <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>5 yrs.</b> <b>5 yrs.</b>
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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>H2O.</b>			
22. I hereby certify that I attended the deceased from <b>Jan, 1942</b> , to <b>June, 1950</b> , that I last saw the deceased alive on <b>June 21, 1950</b> , and that death occurred at <b>8:00 P.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Martin W. Lewis, M.D.</b> (Degree or title)				23b. ADDRESS <b>539 N Grand</b>		23c. DATE SIGNED <b>6/23/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>June 26, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Lutheran Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>JUN 26 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Pascoe</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.</b>		

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

Dr. Martin W. Davis

OR

Dr. Chas. Miller

Humboldt Bldg.

10:00 - 3:00 every day

5:00 - 7:00 Tuesday & Friday

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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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed..... *Max L. Warfel*

Licensed Embalmer No. *4170*

P. O. Address *1936 St. Louis*

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.