

FILED AUG 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28364**
Registrar's No. **6875**

#112914

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place) 5 wks.		2039	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		3. STREET ADDRESS (If rural, give location) 7055 Lansdowne	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) ALBERT	b. (Middle)	c. (Last) KIRCHHOFF	August 11th, 1950		

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 16th 1887	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Hours 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY 0		11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Joseph Kirchoff	13b. MOTHER'S MAIDEN NAME Mary (unknown)	14. NAME OF HUSBAND OR WIFE Esther Kirchoff
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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) No.	16. SOCIAL SECURITY NO. 194-09-3851	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Austin Kirchoff St. Louis Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 mo.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic carcinoma with metastases		
	ANTECEDENT CAUSES Morbidity 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION D	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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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? 162X
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22. I hereby certify that I attended the deceased from **7/7/50**, 19**50**, to **8/11/50**, 19**50**, that I last saw the deceased alive on **8/11/50**, 19**50**, and that death occurred at **4:25pm** m., from the causes and on the date stated above.

23a. SIGNATURE Gary B. Wood M.D.	(Degree or title)	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 8/12/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/14/50	24c. NAME OF CEMETERY OR CREMATORY St. Mathews Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. AUG 13 1950	REGISTRAR'S SIGNATURE J. B. Sasser	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Jay B. Smith 7450 Manchester Rd. Maplewood, Mo.
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

J. Allen Davis
.....
Licensed Embalmer No. 4053

Signed.....
Student Embalmer

P. O. Address H. Lane

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.