

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076

1. PLACE OF DEATH a. COUNTY St. Louis County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 4810	
b. CITY (If outside corporate limits, write RURAL and give township) LAKEWOOD		c. CITY (If outside corporate limits, write RURAL and give township) 8/TOWN St. Louis County	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8135 Gravois		d. STREET ADDRESS (If rural, give location) 8135 Gravois	

3. NAME OF DECEASED (Type or Print) a. (First) F. b. (Middle) Wm. c. (Last) Kuehl			4. DATE OF DEATH (Month) (Day) (Year) Nov. 10 1950		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower 2	8. DATE OF BIRTH March 26 1876	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Atty. At Law		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis Mo. 0		12. CITIZEN OF WHAT COUNTRY?	
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13a. FATHER'S NAME Joachim Kuehl		13b. MOTHER'S MAIDEN NAME Franciska Kiel		14. NAME OF HUSBAND OR WIFE Marie (Deceased)	
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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. 489-14-6571		17. INFORMANT'S SIGNATURE OR NAME Est. Elsie Miller		ADDRESS 8135 Gravois	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL FAILURE.				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause. (a) stating the underlying cause last. DUE TO (b) ARTERIOSCLEROSIS					
		DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				1500	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4:21		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)	
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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?	
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22. I hereby certify that I attended the deceased from **8-28, 1950**, to **9-1, 1950**, that I last saw the deceased alive on **Nov 9, 1950**, and that death occurred at **2:01 PM**, from the causes and on the date stated above.

23a. SIGNATURE Eugene H. Strittmatter		(Degree or title) D.O. 2		23b. ADDRESS 8120-A GRAVOIS AVE		23c. DATE SIGNED Nov. 11, 1950	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial (1)		24b. DATE 11-14-50	24c. NAME OF CEMETERY OR CREMATORY St. Paul Church Yard	24d. LOCATION (City, town, or county) (State) St. Louis County	
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DATE REC'D BY LOCAL REG. 11/14/50		REGISTRAR'S SIGNATURE Herbert R. Tomke MD		25. FUNERAL DIRECTOR'S SIGNATURE Wm. Schumacher		ADDRESS 3013 Meramec	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr Schlittmatter
8120^a Gravois FH 7759

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 _____

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working under my personal supervision.

Student Embalmer No.

Signed.....

J. Francis Williamson

Signed.....
Student Embalmer

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.