

FILED JAN 25 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3387

BIRTH NO.		REG. DIST. NO. 317	PRIMARY REG. DIST. NO. 6076	Registrar's No. 129
1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay 4860
d. FULL NAME OF HOSPITAL OR INSTITUTION: 2546 Rose Garden		d. STREET ADDRESS (If rural, give location) 2546 Rose Garden 0		
3. NAME OF DECEASED (Type or Print) Dorothy		a. (First)	b. (Middle)	c. (Last) Kohlmann
4. DATE OF DEATH (Month) (Day) (Year) 1/15/51				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 6, 1905	9. AGE (In years last birthday) 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri 0
12. CITIZEN OF WHAT COUNTRY? USA				
13a. FATHER'S NAME Frank Zaitz		13b. MOTHER'S MAIDEN NAME Frances M. Moder		14. NAME OF HUSBAND OR WIFE Lawrence
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lawrence Kohlmann-2546 Rose Garden Lemay 23, Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 day		
* This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		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"/>
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Jan 1, 1950, to Jan 15, 1951, that I last saw the deceased alive on Jan 1, 1951, and that death occurred at 12:15 p.m., from the causes and on the date stated above.				
23a. SIGNATURE B. J. Mc Guinness (Degree or title)		23b. ADDRESS 16 Hampton Kellie Ave 9-1-16-50		23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/19/51		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri				
DATE REC'D BY LOCAL REG. 1/16/51		REGISTRAR'S SIGNATURE Robert P. Tomber		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Heldule 3634 Gravois

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..... *Frank J. Waukel, Jr.*

Signed.....
Student Embalmer

Licensed Embalmer No. *9645*

P. O. Address *St. Paul, Minn.*

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.