

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10210

State File No.

FILED MAR 24 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2077**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2089	
d. FULL NAME OF HOSPITAL OR INSTITUTION 7905 Church Rd.,		d. STREET ADDRESS (If rural, give location) 618 Schiller Ave.,	

3. NAME OF DECEASED (Type or Print)	a. (First) Gradus	b. (Middle) Kosman	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Mar 3rd 1952
-------------------------------------	--------------------------	---------------------------	-----------	---

5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept 7th, 1971	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MINS. Mins.
--------------------	-------------------------------	---	--	---	------------------------	-----------------------	-------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Holland	12. CITIZEN OF WHAT COUNTRY? US
--	-----------------------------------	--	--

13a. FATHER'S NAME Peter Kosman	13b. MOTHER'S MAIDEN NAME Wilhelmania Tennos	14. NAME OF HUSBAND OR WIFE Annie L. Kosman
--	---	--

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.	17. INFORMANT'S SIGNATURE OR NAME Helen Kosman, 7905 Church Rd.,	ADDRESS
--	-------------------------	---	---------

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, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 da
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bulbar paralysis		
	ANTECEDENT CAUSES DUE TO (b) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT (Specify) SUICIDE HOMICIDE	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? 356.0
---	--	---

22. I hereby certify that I attended the deceased from **Feb 25, 1952**, to **March 3, 1952**, that I last saw the deceased alive on **3-3**, 1952, and that death occurred at **5⁰⁰** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title)	23b. ADDRESS 8201 N. Broadway	23c. DATE SIGNED 3/4/52
-----------------------------------	-------------------	--------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 3/6/52	24c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
---	-------------------------	---	---

DATE REC'D BY LOCAL REG. MAR 4 1952	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Diedrich F. Home,	ADDRESS 8319 Hallsferry
--	--	---	--------------------------------

(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 *Eleanor Poirice*

Licensed Embalmer No. *3403*

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.