

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 2 - 1952

 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5790

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>5790</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>51 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		<u>2029</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>St. Johns Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>5620 Eichelberger Avenue</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Eugene</u>		b. (Middle) <u>Albert</u>		c. (Last) <u>Kuhlhoff</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 19, 1952</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 30, 1900</u>		9. AGE (In years last birthday) <u>51</u> if UNDER 1 YEAR Months Days if UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William C. Kuhlhoff</u>			13b. MOTHER'S MAIDEN NAME <u>Frances Zeltmann</u>			14. NAME OF HUSBAND OR WIFE <u>Grace George</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Grace Kuhlhoff, 5620 Eichelberger Ave</u>			
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) <u>Brain Tumor - Malignant</u> INTERVAL BETWEEN ONSET AND DEATH <u>4-6 wks.</u> ANTECEDENT CAUSES Morbid 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 <u>6/18/52</u>		19b. MAJOR FINDINGS OF OPERATION <u>Brain tumor - Malignant - Left Temp</u>				20. AUTOPSY? YES <input checked="" 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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>193X</u>			
22. I hereby certify that I attended the deceased from <u>6/6, 1952</u> , to <u>6/19, 1952</u> , that I last saw the deceased alive on <u>6/19, 1952</u> , and that death occurred at <u>11:50 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. A. Smolik, M.D.</u>				23b. ADDRESS <u>Beaumont Mt. Bldg.</u>		23c. DATE SIGNED <u>6/30/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>6/23/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JUN 2 1952</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Beiderwieden F. H. Inc., 1936 St. Louis Ave</u>			

Dr. E. A. Smolik, Beaumont Bldg.

Hours 2 - 4 Mondays & Friday

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 Max L. Warfel

Licensed Embalmer No. 4150

P. O. Address 1936 St Louis Ave

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.