

FILED APR 21 1954

STANDARD CERTIFICATE OF DEATH

State File No.

 BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3048**

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 township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		e. STREET ADDRESS (If rural, give location) 15 4422 Beethoven	

3. NAME OF DECEASED (Type or Print) Mathilda Koste			4. DATE OF DEATH (Month) (Day) (Year) 4/3/54		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married	8. DATE OF BIRTH Mar. 20, 1887		9. AGE (In years last birthday) 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Louis Bredenkoetter		13b. MOTHER'S MAIDEN NAME Anna Ollert		14. NAME OF HUSBAND OR WIFE Fred W.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fred W. Koste-4422 Beethoven	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		ANTECEDENT CAUSES Ch. nephritis & Anabasis			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
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, 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) 260X			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		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 3/30, 1954, to 4/3/54, that I last saw the deceased alive on 4/3/54, and that death occurred at 1:10 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ralph Berg M.D.			23b. ADDRESS 3205 S. Grand		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4/6/54		24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	
				24d. LOCATION (City, town, or county) (State) S. Louis Co., Missouri	

DATE REC'D BY LOCAL REG. APR 5 1954		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Welder - 3634 Gravois Ave.	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

 No. 300
 10-48

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.....
Signature of Student Embalmer

Signed *Robert Wheeler*.....

Licensed Embalmer No. *2128*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.