

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2818

State File No. \_\_\_\_\_

FILED JAN 17 1956

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>19</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>(New) Faith Hospital</b>				STREET ADDRESS (If rural, give location) <b>4804 Cupples Pl. 20670</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Olinda</b>		b. (Middle) <b>E.</b>		c. (Last) <b>Kuhlmann</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>January 1st 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 30 1879</b>		9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 12 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Weldon Springs Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>0</b>	
13a. FATHER'S NAME <b>Julius Fey</b>			13b. MOTHER'S MAIDEN NAME <b>Emma Burgermeister</b>		14. NAME OF HUSBAND OR WIFE <b>Gustave F. Kuhlmann</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Talitha Fey</b>		ADDRESS <b>4804 Cupples Place</b>	
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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypertensive Cardio-Vascular</b>  ANTECEDENT CAUSES DUE TO (b) <b>Renal Disease</b> DUE TO (c) <b>Cerebral Hemiplegia - Arteriosclerosis, Generalized</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>2 yrs ago</b>	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <b>442x</b>					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) _____		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 _____, 1952, to 1-1, 1956, that I last saw the deceased alive on 1-1, 1956, and that death occurred at 8:25 P.M. from the causes and on the date stated above.							
23a. SIGNATURE <b>Joseph B. Lucerne M.D.</b> (Degree or title)				23b. ADDRESS <b>2801 N. Taylor</b>		23c. DATE SIGNED <b>1-3-56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>1/4/56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>E. &amp; R. Church Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Weldon Springs Mo.</b>		
DATE REC'D BY LOCAL REG. <b>JAN 3 1956</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Sullivan's</b>		ADDRESS <b>2849 No. Euclid Ave.</b>	

m. J. B. (Licensed Embalmer's Statement on Reverse Side)

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

Dr. Geesman  
Faith Holy  
EV 1 8800

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 *Albert Mayfield*

Licensed Embalmer No. *307*

P. O. Address *St Louis*

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.