

FILED NOV 16 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35759**  
Registrar's No. **9029**

**318**

**1003**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		REGISTRAR'S NO. _____	
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) <b>5 wks.</b>		c. CITY OR TOWN <b>St. Louis</b>		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 <b>St. Johns Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>3954 a Ashland Ave.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Elizabeth</b>			b. (Middle) _____			c. (Last) <b>Kohlenbach</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>9 30 56</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	
8. DATE OF BIRTH <b>Oct. 1, 1865</b>		9. AGE (In years last birthday) <b>90</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____	
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 <b>Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Stephen Kohlenbach</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Kemper</b>			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or date of service) <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Jos. Kohlenbach 3954 a Ashland</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.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: <b>encephalomalacia</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerotic Heart Disease</b>				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>332 x</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) (Min.) _____	
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 <b>Aug 20, 56</b> , to <b>Sept 30, 56</b> , that I last saw the deceased alive on <b>Sept 30, 1956</b> , and that death occurred at <b>2:00 pm.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) <b>H. J. Siesner M.D.</b>				23b. ADDRESS <b>6000 W Florissant</b>		23c. DATE SIGNED <b>10-1-56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24b. DATE <b>Oct. 3, 1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>	
DATE REC'D BY LOCAL REG. <b>OCT 2 1956</b>		REGISTRAR'S SIGNATURE <b>Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Drehmann-Harral</b>		ADDRESS <b>1905 Union</b>	

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

Dr. H. H. Slesesner  
Marla Medical Bldg.  
Room 104  
6000 West Florissant  
Ev. 3-0127

Hrs. 1 - 5 PM

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 *Warren A. Carver*.....

Licensed Embalmer No. *353*

P. O. Address .....

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.