

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11658
STATE FILE NUMBER

FILED MAR 29 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 236

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Ferdinand TWP		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN St. Ferdinand		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robbin Mill Rd		Length of stay in 1b 91 yrs	d. STREET ADDRESS R# 1 Box 337		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) WILHELMINA			First KAHRE		Last
4. DATE OF DEATH March 18th, 1957			Date Month Day Year		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 19th 1865		9. AGE (In years last birthday) 91
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 country) St. Louis Co., Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Adolph Lindemann			14. MOTHER'S MAIDEN NAME not known		Henry G. Kahre (husband)
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. none		17. INFORMANT Henry Kahre, R#1 Box 337 Florissant, Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolism					INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Endarteritis					5.
DUE TO (c) none					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) High blood Pressure 4/201					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Hour Month, Day, Year. a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) ✓			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from Dec 17-56 to Mar 19 57 and last saw her alive on 3-18-57 Death occurred at 5:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE A. F. Keller M D		22b. ADDRESS 8410 N Bldway St. Louis		22c. DATE SIGNED 3-19-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 3/21/57	23c. NAME OF CEMETERY OR CREMATORY Salem Ev. Lutheran Cemetery, St. Louis Co., Mo.		23d. LOCATION (City, town, or town) (State) Mo
24. FUNERAL DIRECTOR DIEDRICH FUNERAL HOME, 8319 Hallsferry		ADDRESS		25. DATE RECD. BY LOCAL REG. 3/19/57	26. REGISTRAR'S SIGNATURE Deibel B. Donnelly

Name of Deceased: _____
 Date of Death: _____
 Place of Death: _____
 Name of Embalmer: _____
 Date of Embalming: _____
 Place of Embalming: _____
 Name of Undertaker: _____
 Address of Undertaker: _____
 City: _____ State: _____
 License No. of Embalmer: _____
 Signature of Embalmer: _____
 Date of Statement: _____

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 G. W. Wilkinson

Licensed Embalmer No. 35

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.