Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007333
STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1611

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) City Hospital — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 5206 Alaska — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Rose Kuehnle

4. DATE OF DEATH Month Day Year: 2/13/59

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/30/1886

9. AGE (In years last birthday): 72 — 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): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): St. Louis, Mo

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Thomas Kren

13b. MOTHER'S MAIDEN NAME: Josephine --------

14. NAME OF HUSBAND OR WIFE: William Kuehnle

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.: unk.

17. INFORMANT Address: William Kuehnle 5206 Alaska

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Haemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Hypertension — 1 yr.

DUE TO (c): 331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): ——

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Jan 15/58, to Feb. 13/59 and last saw her/him alive on 2/13/59 -
Death occurred at 7P: m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C.W. Gardner

22b. ADDRESS: 1504 So. Grand.

22c. DATE SIGNED: 2/14/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 2/17/59

23c. NAME OF CEMETERY OR CREMATORY: St. Peter and Paul

23d. LOCATION (City, town, or county) (State): St. Louis, Mo

24. FUNERAL DIRECTOR ADDRESS: Edward Fendler Mortuary 5611 S Grand Bl

25. DATE RECD. BY LOCAL REG.: FEB 16 '59

26. REGISTRAR'S SIGNATURE: Carl Smith. M.D. M.G.B.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Hadley P. Fuller Jr

Licensed Embalmer No. 4950

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.