

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D MAR 13 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791
1003

4934
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No. **1627**
(c) City ST. LOUIS MO. (d) Street No. 4571 KENSINGTON PLACE St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? 56 yrs. mos. da.

2. PRINT FULL NAME BARBARA COHLMAN

(a) Residence, No. 4571 KENSINGTON PLACE St. 12 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>FEMALE</u>	4. COLOR OR RACE <u>WHITE</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>WIDOW</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OF (OR) WIFE OF <u>COHLMAN</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>APRIL 9-1865</u>		
7. AGE	YEARS <u>73</u>	MONTHS <u>10</u>
	DAYS <u>10</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>HOUSEKEEPER</u>	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>GERMANY</u>	
FATHER	13. NAME <u>MADINE FREDRICK</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>GERMANY</u>	
MOTHER	15. MAIDEN NAME <u>MARGARET HURLEY</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>GERMANY</u>	
17. INFORMANT (ADDRESS)	<u>Barbara Cohlman</u> <u>4571 Kensington Place</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE	<u>ZION CEMETERY</u> DATE <u>FEB. 20 1939</u>	
19. FUNERAL DIRECTOR (NAME) (ADDRESS)	<u>E. J. Schurz</u> <u>3125 Lafayette Ave.</u>	
20. FILED	<u>FEB 20 1939</u> <u>J. B. Beedeck</u> Local Registrar.	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) FEB. 18 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 17 1936 to Feb 15 1939
I last saw her alive on 2-18, 1939. Death is said to have occurred on the date stated above, at 1:30 p.m.
The principal cause of death and related causes of importance were as follows:
Chc Myocarditis
Chc Paratyphoides typhoides

Date of onset about 1934

Other contributory causes of importance: 131

Name of operation..... Date of.....
What test confirmed diagnosis? lab + clinic Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of Injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of Injury.....

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) J. B. Beedeck, M. D.
(Address) 315 So. Grand

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Joseph B. Dillman

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette av*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.