

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 317

Primary Registration District No. 3066

Registrar's No. 1847

**1. PLACE OF DEATH:**

(a) County St. Louis 2

(b) City or town Kirkwood  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 7 years  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Louis 4

(c) City or town Kirkwood 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 728 N. Clay Ave  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country No 0

**3. (a) PRINT FULL NAME** Adele Bolte

3. (b) If veteran, name war no 3. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 26 1894  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

48 9 11 hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Invalid at home

11. Industry or business \_\_\_\_\_

12. Name Frederick S. Bolte

13. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Rosine Koenigkraemer

15. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address 728 N. Clay Ave.

17. (a) Burial (b) Date thereof 8/10/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Walter Gross

(b) Address Walter Gross

19. (a) AUG 13 1943 (b) C. J. McLaughlin  
(Date received local registration) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 7  
year 1943 hour 9 minute 15 a.m.

21. I hereby certify that I attended the deceased from 8-4 1943 to 8-7 1943  
that I last saw him alive on 8-6 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Duration 2 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 934

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature C. E. Barnett (M. D. or other) \_\_\_\_\_  
Address 243 W. Jefferson Ave. Date signed 8-9-43

MOTHER FATHER

**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.....

*J. Allen Davis*

Licensed Embalmer No.....

*4053*

P. O. Address.....

*City*

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

**If this body is not embalmed, fact should be so stated above.**