

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. **8966**

FILED OCT 22 1943
 Registration District No. **318**
 Primary Registration District No. **1003**

1. PLACE OF DEATH:
 (a) County **St. Louis Mo.**
 (b) City or town _____
 (c) Name of hospital or institution:
At home 2823 Nebraska
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **St. Louis Mo.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **2823 Nebraska**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Kunigunda H. Behr**
 3. (b) If veteran, name war **No** 3. (c) Social Security No. **NO**
 4. Sex **Female** 5. Color or face **White**
 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 **Aug. 9th 1890**
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **10** day **9th**
 year **1943** hour **650** minute **pm** M.
 21. I hereby certify that I attended the deceased from **1-15-43**
 _____, 19____, to _____, 19____
 that I last saw ~~her~~ **her** alive on **10-9-43**, 19____
 and that death occurred on the date and hour stated above.

8. AGE: Years **53** Months **2** Days **2**
 If less than one day _____ hr. _____ min.
 9. Birthplace **St. Louis**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **At home**
 11. Industry or business _____
 12. Name **Oswald Behr**
 13. Birthplace **Germany** (State or foreign country) **4**
 14. Maiden name **Anna Homer**
 15. Birthplace **Germany** (State or foreign country) **4**

Immediate cause of death **Chronic myocarditis**
 Duration **9 months**
 Due to _____
 Due to _____
 Other conditions **Fibrillation**
 (Include pregnancy within 3 months of death) **9 months**
 Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Anna Behr**
 (b) Address **2823 Nebraska**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10 12 43**
 (Month) (Day) (Year)
 (c) Place: burial or cremation **S. S. Peter & Paul Cem.**
 18. (a) Signature of informant **Anna Behr**
 (b) Address **114 1/2 Grand Blvd.**
 19. (a) _____ (b) **J. J. Brueck**
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **no**
 (b) Date of occurrence **no**
 (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 **J. J. Brueck** (M. D. or other) **MD**
 Address **2767 Travis** Date signed **10-11-43**

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

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.....

Signed

John Gonowski
.....

Licensed Embalmer No. *2348*.....

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