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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

**FILED AUG 27 1946** STANDARD CERTIFICATE OF DEATH

28317

State File No. \_\_\_\_\_

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1718

**1. PLACE OF DEATH:**

(a) County St. Louis  
(b) City or town Koch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Robert Koch Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 6 mos., 17 days (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4947 Thrush Ave 9  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Theodore Haller

3. (b) If veteran, name war No.  
3. (c) Social Security No. 490-05-0537

4. Sex M. O. 5. Color or race W.  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Bernice Haller  
6. (c) Age of husband or wife if alive 35 years  
7. Birth date of deceased April 23 1911  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
35 3 26 hr. min.

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

10. Usual occupation Engineer

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

12. Name Emanuel Haller

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Barthe

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Record

(b) Address \_\_\_\_\_

17. (a) burial (b) Date thereof 8-19-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd.

19. (a) 8-19-46 (b) E. J. M. Jarvanto  
(Date burial local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug day 15  
year 1946 hour 9 minute 50 P.M.

21. I hereby certify that I attended the deceased from Jan 29  
1946 to Aug 15, 1946  
that I last saw him alive on Aug 15, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis meningitis 6 days

Due to Chronic Pulmonary Tuberculosis 3 yrs

Due to 135

Other conditions Tuberculosis laryngitis 9 mos.  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy Tuberculosis of lungs, larynx and meninges

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 U

23. Signature Charles Silverman (M. D. or other) MD  
Address Koch Hospital, Koch, Mo. Date signed 8/16/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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**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 Warren A. Carver

Licensed Embalmer No. 3534

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.**