

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

Do not use this space.

41528

File No.
Registered No. 12218
.....St.Ward)

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City *St. Louis* No. *5109A* *St. Louis* *Ward*

2. FULL NAME *Lusan Symphonia Klauberg*

(a) Residence. No. *5109A* *St. Louis* *ave* St. *6* Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female | *White* | *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Edmund J. Klauberg

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 3, 1848*

7. AGE YEARS MONTHS DAY | IF LESS than 1 day, hrs. or min.

89 | *5* | *26*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *House work*
(b) General nature of industry, business, or establishment in which employed (or employer) *at home*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Unknown*
(STATE OR COUNTRY)

10. NAME OF FATHER *Unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Unknown*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Unknown*
(STATE OR COUNTRY)

14. INFORMANT *Walter A. Klauberg*
(Address) *5621 Theodosia*

15. FILED *DEC 30 1930* *Max C. Starker* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 29 1930*

17. I HEREBY CERTIFY, That I attended deceased from *11/28*, 19*30*, to *12/28*, 19*30*.
that I last saw her alive on *12/28*, 19*30*, and that death occurred, on the date stated above, at *12:55* A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131 Cerebral Hemorrhage

Chronic Interstitial Nephritis (duration) yrs. mos. ds. *3* da.
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED? *at home*
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Chisel*
(Signed) *James A. Sullivan*, M. D.
, 19 *5059^e Ottawa Ave.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Calvary Cemetery* DATE OF BURIAL *12 31 1930*

20. UNDERTAKER *Kueyshausen & Co* ADDRESS *4104th Manchester*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

