

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

Do not use this space.

6352

1. PLACE OF DEATH *At Home*  
 County..... Registration District No. *ST. LOUIS*  
 Township..... Primary Registration District No. *ST. LOUIS*  
 City..... (No. ....) St. .... Ward)  
 2. FULL NAME *Mary Klement*  
 (a) Residence. No. *2160<sup>a</sup> Salisbury* St., *216* Ward. (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred *68* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. ....  
 Registered No. *1384*  
 St. .... Ward)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *F* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Widow*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Widow of John Klement*  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 25, 1863*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*68 6 15*  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work. *Housewife 235*  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....  
 9. BIRTHPLACE (CITY OR TOWN) *St. Louis, Mo.* (STATE OR COUNTRY)  
 10. NAME OF FATHER *Unknown*  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Unknown* (STATE OR COUNTRY) *Germany*  
 12. MAIDEN NAME OF MOTHER *Unknown*  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Unknown* (STATE OR COUNTRY) *Germany*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb. 10 1932*  
 17. I HEREBY CERTIFY, That I attended deceased from *Feb. 7*, 19*32*, to *Feb. 10*, 19*32* that I last saw her..... alive on *Feb. 10*, 19*32*, and that death occurred, on the date stated above, at *3:30 p.* m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*arterio sclerosis*  
*92h* (duration) *5* yrs. mos. ds.  
 CONTRIBUTORY *endocarditis laborum* (SECONDARY) (duration) *1* yrs. mos. ds.  
 18. WHERE WAS DISEASE CONTRACTED *St. Louis*  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
 WAS THERE AN AUTOPSY?.....  
 WHAT TEST CONFIRMED DIAGNOSIS? *St. Joseph*, M. D. (Signed).....  
*Feb 11 1932* (Address) *4117 W. Jefferson*  
 \*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 *Feb. 13 1932*  
 20. UNDERTAKER *Denis Willmuring* ADDRESS *2203 Salisbury*

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.

PARENTS

14. INFORMANT *Mrs. Anna P. Hartmann* (Address) *2160<sup>a</sup> Salisbury St.*  
 15. FILED *11* 19-*2* *Max C. Gable* REGISTRAR

1900