

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

32899
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **2720 Indiana Av** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **8953**

2. PRINT FULL NAME **Catherine Klosterman**

(a) Residence, No. **2720 Indiana Av** St. **23** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **married**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Feb 14 - 1892**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 45 8 10
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **at home**
9. Industry or business in which work was done, as saw mill, bank, etc. **housewife**
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St Genevieve Mo**

13. NAME **Joseph Lorch**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

15. MAIDEN NAME **Elizabeth Hoog**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Genevieve Mo**

17. INFORMANT (ADDRESS) **Joseph Klosterman 2720 Indiana Av**

18. BURIAL, CREMATION, OR REMOVAL PLACE **St Peter - Paul** DATE **Sept 27 1937**

19. FUNERAL DIRECTOR (ADDRESS) **John H. Gebken 2630 Gravois Av**

20. FILED **SEP 25 1937** **J. Bredeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept 24 1937**

22. I HEREBY CERTIFY, That I attended deceased from **1935**, 19... to **9/24**, 19**37**

I last saw her alive on **9/23**, 19**37**. Death is said to have occurred on the date stated above, at **5:45** a.m.

The principal cause of death and related causes of importance were as follows:

Amnrotrophic Lathrae Sclerosis
J. W.
Other contributory causes of importance: **broncho Hypostatic pneumonia** **9/23/37**

Date of onset **ab 1925**

Name of operation **none** Date of...
What test confirmed diagnosis? **Physiologic exam** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? **no** Date of injury... 19...
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury...
Nature of injury...

24. Was disease or injury in any way related to occupation of deceased?
If so, specify **J. E. Benest**, M. D.
(Signed) **J. E. Benest** (Address) **2202 So Broadway**

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.

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1937 4 1937

2202 S Broadway

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____
hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____
_____ L. E. _____
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Hermon A. Gibson

Licensed Embalmer No. 2120

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.)

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