

REC'D MAR 13 1939

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

4310

Do not use this space.

## 1. PLACE OF DEATH

- (a) County.....  
 (b) Township.....  
 or  
 (c) City.....  
 (e) Length of residence in city or town where death occurred

Registration District No. 105 791  
 Primary Registration District No. 1008  
 Registered No. 1003  
 (d) Street No. Firmin Desloge Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 yrs. moa. da. (f) How long in U. S., if of foreign birth? yrs. moa. da.

## 2. PRINT FULL NAME

- (a) Residence, No. 420 Ar. Mrs. Klewais  
4448 Oakland Ave  
 (Usual place of abode, if no street address, write county or city) St. 18  
 (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>January 2 1939</u>		
7. AGE	YEARS	MONTHS
		DAYS
IF LESS than 1 day, 16 hrs. or 4 min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	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)	<u>St. Louis, Mo</u>	
FATHER	13. NAME	<u>Frank J. Klewais</u>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Austria Germany</u>
MOTHER	15. MAIDEN NAME	<u>Marie Wappel</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>St. Louis, Mo</u>
17. INFORMANT (ADDRESS)	<u>Jakob Frank J. Klewais</u> <u>4448 Oakland St. St. Louis, Mo</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE	<u>ST. LOUIS U. S. SCHOOL</u> MEDICINE DATE <u>1/3</u> 19 <u>39</u>	
19. FUNERAL DIRECTOR (NAME) (ADDRESS)	<u>Walter Richter</u> <u>3500 Rutger Str.</u>	
20. FILED	<u>FEB 1 1939</u> <u>J. B. Brudick</u> Local Registrar	

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 3 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 2 1939, to Jan 3 1939  
 I last saw him alive on Jan 3 1939. Death is said to have occurred on the date stated above, at 3:45 a. m.  
 The principal cause of death and related causes of importance were as follows:  
1) - TRACHEO-ESOPHAGEAL FISTULA  
2) - ATRESIA OF BOTH VENTERS  
 Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... 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? no  
 If so, specify.....  
 (Signed) G. A. Mitchell 1, M. D.  
 (Address) 1325 S. Grand

(Licensed Embalmer's Statement on Reverse Side)

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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**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.....

Licensed Embalmer No.....

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, above space should be left blank.**