

DEC 17 1939 791
Registration District No. **1005**

Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis,
(b) City or town Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Anthony Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town St Louis 24
(If outside city or town limits, write "RURAL")
(d) Street No. 2659 California
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME William L. Kleba
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 28 1899
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 21 year 39 — hour 9 minute 25 A.M.
21. I hereby certify that I attended the deceased from Apr 29 1939 to Nov 21 1939 that I last saw him alive on Nov 2 1939 and that death occurred on the date and hour stated above.

8. AGE: Years 40 Months 4 Days 23 If less than one day hr. min.

Immediate cause of death
Hepatitis (Ch) - Septicemia about (Ch) - myocarditis (Ch) 1 year?
Due to not known

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

Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation Plumber

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name William A. Kleba 6

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

14. Maiden name Marg. H. Krug
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Philip H. Kleba

(b) Address 3451 Miami St. II/24/39

17. (a) _____ (b) Date thereof II/24/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director J. H. Gebken Und.

(b) Address 2630 Gravois

19. (a) NOV 22 1939 (b) J. J. Baedek
(Date received local registrar) (Registrar's signature)

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) Means of injury _____
23. Signature Robert T. Warner (M. D. or other) MA
Address Paul Brown Bldg Date signed Nov 22 39

Duration _____
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Dr. Rob. Warner
Paul Brown Blodg

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 Herman A. Gebken

Licensed Embalmer No. 2120

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.