

DEC 13 1939 791

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 10153

1. PLACE OF DEATH: 10083
 (a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. John's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 13 days
 In this community 60 Years
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3429 Humphrey
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Grace T. Klein 450
 3. (b) If veteran, name war. --- No. ---
 3. (c) Social Security No. ---

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month NOV. day 28
 year 1939 hour 11 minute 30 a.m.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Stephen 6. (c) Age of husband or wife if alive 72 years
 7. Birth date of deceased October 10, 1870
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to Nov 28, 1939
 that I last saw her alive on 11/28, 1939
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>1</u>	<u>18</u>	hr. _____ min. _____

Immediate cause of death
Carcinoma Rectum with partial bowel obstruction
 Due to _____

9. Birthplace Kansas City Kansas
 (City, town, or county) (State or foreign country)

Due to H to
 Other conditions Hypertension - Arterio
 (Includes pregnancy within 3 months of death)

10. Usual occupation Home

Major findings: Sclerosis - Myocardial infarction
Int. obstruction partial
due to fusible Carcinoma of rectum sigmoid
 Of operations _____
 Of autopsy _____

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Grace Klein

(b) Address 3429 Humphrey

17. (a) Burial (b) Date thereof 12/1/39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset

18. (a) Signature of funeral director Wacker-Welder
 (b) Address 2331 S. Broadway

19. (a) NOV 28 1939 (b) J.P. Prueck
 (Date received local registrar) (Registrar's signature)

PHYSICIAN
 Underline the cause to which death should be charged statistically

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)
 (e) Means of injury _____

23. Signature Dr. W. W. Hammond (M. D. or other)
 Address 434 W. Grand Blvd Date signed 11/28/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39
 1-1 x9511

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.

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..... *Frank J. Myland Sr.*
Licensed Embalmer No. *2675*
P. O. Address..... *St Louis Mo*

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.