

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42079**
Registrar's No. **11202**

Registration District No. **281** Primary Registration District No. _____

1. PLACE OF DEATH: **1008**
(a) County _____
(b) City or town **ST LOUIS.**
(c) Name of hospital or institution: **ST LOUIS ALTENHEIM.**
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days **45**

8. (a) PRINT FULL NAME **GUSTAVE C. KLEINECKE**
8. (b) If veteran, name war **NO** 8. (c) Social Security No. **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 **NOV. 1 1861**
(Month) (Day) (Year)

8. AGE: Years **78** Months **1** Days **28** If less than one day _____ hr. _____ min.

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

10. Usual occupation **LABORER**
11. Industry or business **RETIRED**

MOTHER FATHER
12. Name **UNKNOWN**
13. Birthplace **UNKNOWN**
14. Maiden name **UNKNOWN**
15. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **John W. Hoyt**
(b) Address **5408 So. Broadway**

17. (a) **BURIAL** (b) Date thereof **DEC. 30-39**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **NEW ST MARCUS, CAM.**

18. (a) Signature of funeral director **J. P. ...**
(b) Address **7128 Michigan Ave.**

19. (a) **DEC 29 1939** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **1**
(c) City or town **St Louis 15**
(d) Street No. **5408 So Broadway**
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **29** day **Dec.**
year **1939** hour **12** minute **35** A. M.
21. I hereby certify that I attended the deceased from **Nov. 27, 39**
to **Dec. 29, 1939**;
that I last saw him alive on **Dec 28, 1939**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial Pneumonia** Duration **1 mo.**
Due to **Upper Respiratory Infection**
Due to _____

Other conditions (Include pregnancy within 3 months of death) **101**
Major findings: Of operations _____
Of autopsy _____
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. Rux / ...** (M. D. or other) _____
Address **3775 S. Grand** Date signed **12/29/39**

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.....

J. P. [Signature]
Licensed Embalmer No. 925
P. O. Address ST LOUIS,

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.