

Registration District No. **791**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(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 _____ (Specify whether _____)
In this community _____ years, months or days

9. (a) PRINT FULL NAME Susan Kleitsch
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 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 March 13 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	<u>9</u> hr. <u>46</u> min.

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

10. Usual occupation Infant

11. Industry or business _____
MOTHER FATHER { 12. Name Donald Kleitsch
13. Birthplace Duluth Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Dorothy Jones
15. Birthplace Robbinsdale Minn.
(City, town, or county) (State or foreign country)

16. (a) Informant Donald Kleitsch
(b) Address 361 So. Maple Ave.

17. (a) Burial (b) Date thereof 3-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New St. Peter Paul Church

18. (a) Signature of funeral director Kriegshauser Mortuaries
(b) Address 4228 So. Kingshighway

19. (a) MAR 15 1940 (b) J. F. [Signature]
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Webster Groves NR
(If outside city or town limits, write "RURAL")
(d) Street No. 361 So. Maple Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 14th
year 1940 hour 5 minute A.M. M.
21. I hereby certify that I attended the deceased from Mar 13/40
_____ 19____, to Mar 14 19____
that I last saw him alive on Mar 13-40 at 8 PM, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Congenital atelectasis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy as above

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 Matthew W. West (M. D. or other) _____
Address 508 No. Grand Ave Date signed 3/14/40

Dr. Mat Wels
Metrop Bldg. 11:30 - 1 P.M.

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 *Edward M. Bennett*
Licensed Embalmer No. *3024*
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.