

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. 76

1. PLACE OF DEATH:

(a) County St. Francois Sr. Fran. Co.
(b) City or town Near Farmington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital No. 4 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Margaret Klund 453

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John Klund 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 17 1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 12 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Henry Hagemann 9

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

14. Maiden name Knocke 9

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

16. (a) Informant's own signature Records of State Hospt. #4

(b) Address Farmington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-1940
(Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cem. Mehlville, Mo.

18. (a) Signature of funeral director Linus C. Hoffmeister
(b) Address 7814 So. Broadway. St

19. (a) Mich 29-40 (b) R. J. Robinson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 29
year 1940 hour 3 minute 50 A.M.

21. I hereby certify that I attended the deceased from 3-9, 1940 to 3-29, 1940
that I last saw her alive on 3-28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Branchial pneumonia Duration 18 hrs.

Due to Arteriosclerosis, generalized + marked ?

Other conditions Senile Psychosis, Single Intention 6 mos +
(Include pregnancy within 3 months of death)

Major findings: Of operations none Of autopsy none
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? no

(e) While at work? _____ (Specify type of place) (f) Means of injury _____

23. Signature C. C. Aust (M. D. or other) M.D.
Address Farmington, Mo. Date signed 4/1/40

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 *Linus C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadway*

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.