

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12521

State File No. _____

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 653

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Lemay Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Telegraph & Ringer Road Route #1 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community Life
years, months or days 5 5 7 1

3. (a) PRINT FULL NAME Amelia Klein

3. (b) If veteran, name war None

8. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Henry Klein

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 15 1865
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>10</u>	<u>17</u>	hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

12. Name John Beck

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

14. Maiden name Catherine Burke

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

16. (a) Informant Wm. Seibland

(b) Address Route #9 Lemay, Mo.

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

(c) Place: burial or cremation St. Pauls con Oakville, Mo.

18. (a) Signature of funeral director C. Hoffmeister U.S.L.C.

(b) Address 7214 S. Broadway

19. (a) APR - 3 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri

(b) County St. Louis

(c) City or town Lemay Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Telegraph & Ringer Road RT. #9
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 50 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2
year 1940 hour 10 minut. 30 a. M.

21. I hereby certify that I attended the deceased from Feb 3 - 39
_____ 1940 to Apr 2 1940
that I last saw her alive on Mar 30 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic Endocarditis

Due to _____

Due to 92a

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

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

707

While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature Waldorf Hill (M. D. or other) _____

Address Lemay R 8 Ma Date signed 4/2/40

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

SV WINE L
MELBROOK

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 E. Hoffmeister

Licensed Embalmer No. 2871

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17-521
Registrar's No. 653

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 784

Primary Registration District No. 200

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

3. (a) PRINT FULL NAME Amelia Klein

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 74 Months 10 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-3-40 (b) J.P. Mag... (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 7 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him _____ alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 W. H. ... (M. D. or other) _____

Address Lesnay R 8 Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

1940

S-12521