

No. 2
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17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23872

State File No. _____

ED AUG 25 1940
Registration District No. 2791

Primary Registration District No. 1003

Registrar's No. 6317

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:
5459 Vera Ave.
(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

8. (a) PRINT FULL NAME Lena Klenke 452

8. (b) If veteran, name war no 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 John Klenke 6. (c) Age of husband or wife if alive _____ years
deceased

7. Birth date of deceased August 23, 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 11 3 28 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Oliver Klingling
(b) Address 5459 Vera Ave.

17. (a) Burial (b) Date thereof July 29 '40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Brommshurg & Co
(b) Address 4746 W. Florissant Ave.

19. (a) JUL 28 1940 (b) J. F. Breddeck
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 7
(If outside city or town limits, write "RURAL")
(d) Street No. 5459 Vera Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
year 1940 hour 18 minute 15 P.M.

21. I hereby certify that I attended the deceased from Aug. 1938 to July 26 1940;
that I last saw her alive on July 23 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic Interstitial Nephritis & Coronary Sclerotic
Due to of interstitial 3-4 yrs.

Other conditions Arteriosclerosis, General
(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? _____

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

23. Signature Francis C. Campbell (M. D. or other) M.D.
Address 422 N. Taylor Date signed July 27, 40

Dr. Canyker

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 *Albert G. Kopp*

Licensed Embalmer No. 2971

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.