. No. 2
-11-10-39
5-17-39
PI X21492

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

9444

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37452

Registration District No. 791 1 | Primary Registration District No. 1003 | Registrar's No. 9725

FILED DEC 11 1940

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: Bethesda Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 84 days (Specify whether years, months or days)

In this community 84 days

2. USUAL RESIDENCE OF DECEASED: NR

(a) State Mo. (b) County St. Louis

(c) City or town ~~St. Louis~~ Kirkwood
(If outside city or town limits, write "RURAL")

(d) Street No. ~~Bethesda Hospital~~ 746 No Woodlawn
(If rural, give location)

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

3. (a) PRINT FULL NAME Betty Lou Klein

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 23 (Day) 1940 (Year)

8. AGE: Years | Months 2 | Days ~~24~~ 23 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Violet Klein
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Violet Klein
(b) Address 746 N. Woodlawn

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11-28-40 (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Ira Hamilton
(b) Address City Health Dept.

19. (a) Nov 27 1940 (Date received by local registrar) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16 year 1940 hour 3:00 minute P. M.

21. I hereby certify that I attended the deceased from Aug. 23 1940 to Nov. 16 1940 that I last saw her alive on Nov. 16 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Congenital obstruction colon	
Due to 1) Prematurity	
Due to 2) ~~[illegible]~~	
Other conditions Atelectasis of Rt. Lung (Include pregnancy within 3 months of death)	

Major findings: Of operation Obstruction of colon

Of autopsy Atelectasis of Rt. Lung.

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? (Specify type of place)

While at work (e) Means of injury

23. Signature J. E. Schorger (M. D. or other)

Address Bethesda Date signed 11-16-40

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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.