

JUN 6 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18992

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1096

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Rose Sanatorium
(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)

3. (a) PRINT FULL NAME KLEIN, LEONA

3. (b) If veteran, name war No. 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 Single 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 31 1914
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
26 8 21 hr. _____ min.

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

10. Usual occupation None

11. Industry or business

MOTHER FATHER { 12. Name Julius Klein
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Mary Frank
15. Birthplace New London, Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Margaret Dugan
(b) Address East St. Louis, Ill.

17. (a) Removal (b) Date thereof 5-22-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Ill.

18. (a) Signature of funeral director Robert A. Hoppe
(b) Address 400 Washington Blvd

19. (a) MAY 22 1941 (b) R. Meyer MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair
(c) City or town East St. Louis, Illinois
(If outside city or town limits, write "RURAL")
(d) Street No. 2554 Monroe Avenue
(If rural, give location) 2
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 21
year 41 hour 2 minute A. M.

21. I hereby certify that I attended the deceased from 1/30, 1940, to 5/21, 1941

that I last saw him alive on 5/21, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Far Advanced Pulmonary Tuberculosis Duration 2 1/2 yrs

Due to _____
Due to _____

Other conditions The Laryngitis 4 mos.
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
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? _____

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

23. Signature Lois E. Gerson (M. D. or other) _____
Address St. Rose Sanatorium Date signed 5-21-41

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

9600

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 *Guy W. Wilkinson*

Licensed Embalmer No. 3575

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.