

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1943 MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22651

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

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

8. (a) PRINT FULL NAME George Kloppenburg

8. (b) If veteran, name war No 8. (c) Social Security No None

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

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

7. Birth date of deceased April ? 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 2 ? hr. min.

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

10. Usual occupation Labor (Retired)

11. Industry or business _____

MOTHER FATHER { 12. Name Henry Kloppenburg
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Catherine Timme
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Kloppenburg

(b) Address Florissant, Mo.

17. (a) Burial (b) Date thereof June 26, 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Florissant, Mo.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave.

19. (a) JUN 25 1941 (b) K. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24
year 1941 hour 5 minute 30 A.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 Natural causes. Duration _____

Due to Bronchial pneumonia

Due to 107
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy Yes

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 Charles H. Hoff (M.D. or other)
Address Kirkwood, Mo. Date signed 6/24/41

10-1-1914

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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

John M. Meyer

Licensed Embalmer No.

3288

P. O. Address

Kirkwood Mo

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.

10-1-1914