

S. No. 2
A-1.4-41
7. 5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7821

State File No. 2

Registrar's No. 501

MAR 11 1943

Registration District No. 284

Primary Registration District No. 112

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

1. PLACE OF DEATH:

(a) County St. Louis Rock Hill

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

(c) Name of hospital or institution:
817 Blossom Lane
(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 Marie Klorer

3. (b) If veteran, name war _____

3. (c) Social Security No. none

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife James B. Klorer

6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased May 9 1914
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

28 9 17 hr. min.

9. Birthplace St. Louis 0
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER

12. Name Frank Kirk

13. Birthplace St. Louis Mo 0
(City, town, or county) (State or foreign country)

14. Maiden name Theresa Cullen Mo 0

15. Birthplace St. Louis Mo 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dorothy ODonnell

(b) Address 4502 Fair Ave.

17. (a) Burial (b) Date thereof March 1 1943
(Burial, cremation, or removal) (Month) (D.) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Chas. J. Stuart

(b) Address 1225 Union Blvd

19. (a) MAR 1 1943 (b) Wm Luman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 96

(a) State Missouri (b) County St. Louis 14

(c) City or town Rock Hill 0
(If outside city or town limits, write "RURAL")

(d) Street No. 817 Blossom Lane
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 26th
year 1943 hour 2 minute 10 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 A mass in the distal end of right fallopian tube;

Due to Rupture of right fallopian tube; Hemorrhage into peritoneal cavity.

Other conditions toneal cavity.
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy Yes. 139/21

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 Wm Luman (M.D. or other) _____

Address Kirkwood, Mo. Date signed 2-27-43

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 *Welford G. Burdley*
Licensed Embalmer No. *4202*

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, fact should be so stated above.