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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25852

FILED AUG 28 1945

Registration District No. 8 18 Primary Registration District No. L 1003 Registrar's No. 7030

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

1. PLACE OF DEATH:

(a) County

(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. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1MO-7days (Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis, 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4038 Phillips, 7 16
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME FRED KLING

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept. (Month) 11 (Day) 1879 (Year)

8. AGE: Years 65 Months 10 Days 28 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER

12. Name Unknown

13. Birthplace do (City, town, or county) 0 (State or foreign country)

14. Maiden name do

15. Birthplace do (City, town, or county) 0 (State or foreign country)

16. (a) Informant Mr. William Vogts

(b) Address 4038 Phillips,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/45 (Month) (Day) (Year)

(c) Place: burial or cremation St. Paul's Churchyard

18. (a) Signature of funeral director Oscar J. Hoffmeister

(b) Address 4016 Chippewa,

19. (a) AUG 10 1945 (Date received local registrar) (b) J. F. Buck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 9th year 1945 hour 6:30 minute A M.

21. I hereby certify that I attended the deceased from 7/2/45, 19..., to 8/9/45, 19...; that I last saw him alive on 8/9/45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchogenic Carcinoma

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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 Herbert C. Fritz (M. D. or other)

Address 1515 Lafayette Date signed 8/9/45

(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 Albert G. Hoppe

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, fact should be so stated above.