

**FILED** SEP 8 1945  
Registration District No. 377

Primary Registration District No. 3063

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

16  
22  
6

**1. PLACE OF DEATH:**

(a) County St. Louis  
 (b) City or town Clayton, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis Co. Hosp. 10  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 9-2-45-8:30 P.M. to 9-3-45  
(Specify whether)  
 In this community 22 yrs  
years, months or days

**3. (a) PRINT FULL NAME** KLEISSHE, HAZEL

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Joseph Kleissle (dec)

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

7. Birth date of deceased 6-6-95  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>50</u>	<u>2</u>	<u>28</u>	hr. min.

9. Birthplace Syracuse - New York  
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business none

**MOTHER FATHER**

12. Name Charles R. Bartig

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

14. Maiden name Elizabeth Ori

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

16. (a) Informant Mrs. Irving Kleissle

(b) Address 1630 1/2 Duenda Avenue

17. (a) Burial (b) Date thereof 9-7-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Geo. L. Pleitach, Inc.

(b) Address 5966-68 Eastern Avenue

19. (a) 9-6-45 (b) G. M. Baran m  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County St. Louis 9th

(c) City or town Nourmandy, Mo.  
(If outside city or town limits, write "RURAL")

(d) Street No. 3715 St. Ann's Lane  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 9 day 3  
 year 1945 hour 1 minute 05 P.M.

21. I hereby certify that I attended the deceased from 9-2-45  
(8:30 P.M.), 1945, to 9-3-45 (11:05 P.M.)  
 that I last saw her alive on 9-3-45  
 and that death occurred on the date and hour stated above.

Immediate cause of death Emaciation - Malnutrition & Delirium

Due to \_\_\_\_\_

Due to 200a

Other conditions —  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)

(a) Means of injury \_\_\_\_\_

23. Signature Osma Hendon M. D. or other \_\_\_\_\_  
 Address 601 Brentwood Date signed 9-4-45

**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

*Clement M. Murphy*

Licensed Embalmer No. *3732*

P. O. Address

*St. Louis*

**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.**