

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STANDARD CERTIFICATE OF DEATH  
1003

39381

State File No.  
Registrar's No. 10912

Registration District No. 318 Primary Registration District No. Registrar's No. 10912

1. PLACE OF DEATH:  
(a) County St. Louis, Mo.  
(b) City or town St. Louis  
(c) Name of hospital or institution: 5554 Cabanne  
(d) Length of stay: 1  
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County  
(c) City or town St. Louis  
(d) Street No. 5554 Cabanne  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Robert John Klenk  
3. (b) If veteran, name war none 3. (c) Social Security No. none  
4. Sex Male 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 December 14 1945 (Month) (Day) (Year)

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

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

10. Usual occupation none

11. Industry or business none

12. Name George Klenk

13. Birthplace North Platte, Neb. (City, town, or county) (State or foreign country)

14. Maiden name Pauline Stovick

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

16. (a) Informant George Klenk (b) Address 5554 Cabanne

17. (a) Burial (b) Date thereof Dec 15 45 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director (b) Address 2710 N. Grand Blvd.

19. (a) DEC 15 1945 (Date received local registrar) (b) J. F. Breueck (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 14 day 22 year 1945 hour 4 minute 45 a.m.  
21. I hereby certify that I attended the deceased from Dec 14 1945 to Dec 14 1945 that I last saw him live on Dec 14 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Inducement, Instrumental

Due to: drug

Due to: 1/20

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

Major findings: Of operations: Of autopsy:

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: J. F. Breueck (M. D. or other) Address: Date signed

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

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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..... *Carl P. Trovost* .....

Licensed Embalmer No. *1578* .....

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.**