

UNITED STATES HEALTH DEPARTMENT
STANDARD CERTIFICATE OF DEATH
1003

State File No. **14910**
Registrar's No. **3205**

FILED APR 18 1946
318

Registration District No.

Primary Registration District No.

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

13810

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... ST. LOUIS, MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
JEWISH HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3/4/46 to 4/5/46
(Specify whether
In this community..... 50 yrs.
years, months or days)

3. (a) PRINT FULL NAME Ester Ploudre Kluner

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex F. / 5. Color or race W.

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

6. (b) Name of husband or wife William Kluner

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

7. Birth date of deceased Jan. 11, 1874
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>2</u>	<u>24</u> hr. min.

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

10. Usual occupation At Home

MOTHER FATHER

11. Industry or business.....

12. Name..... Unk. Ploudre

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

14. Maiden name..... Emily Unknown

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

16. (a) Informant Mr. Raymond Kluner

(b) Address 3751a Cote Brilliante

17. (a) Burial, cremation, or removal Burial (b) Date thereof 4-8-46
(Month) (Day) (Year)

(c) Place: burial or cremation Calyary

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) APR 7 1946 (b) J. F. Budiek
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo. (b) County..... 000

(c) City or town..... St. Louis 11 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3751a Cote Brilliante Ave. 9 10
(If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 5
year 1946 hour 6 minute 10 P.M.

21. I hereby certify that I attended the deceased from 7/12/45
....., 19....., to 4/5/46, 19.....
that I last saw her alive on 4/5/46, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Carcinoma of
Esophagus with
metastases

Due to.....

Due to.....

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

Duration

PHYSICIAN

Major findings:
Of operations..... Typhloplasty - Peeking
of hepatic tissue - Ca
Of autopsy..... NONE

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 Fredman Wash (M. D.) or other) 0

Address 20 Jewish Hospital Date signed 4/9/46

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 W. Van Matre.....

Licensed Embalmer No. 2825.....

P. O. Address 4340 Lafayette.....

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.