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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 17 1948 STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4259**

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

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: 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 _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME MARY KLEEKAMP
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced SINGLE
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: JULY (Month) 21 (Day) 1865 (Year)

8. AGE: Years 80 Months 0 Days 19 If less than one day hr. _____ min. _____

9. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER { 12. Name HENRY KLEEKAMP
13. Birthplace GERMANY MISSOURI
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant H. CARL HEIGOLD

(b) Address 5371 GERALDINE AVE.

17. (a) RURAL (b) Date thereof 5-13-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director [Signature]

(b) Address 2117 E GRAND BLVD

19. (a) MAY 11 1948 (Date received local registrar) J. F. Bredenk (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 5371 GERALDINE AVE.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 10
year 1946 hour 6:30 minute A M.

21. I hereby certify that I attended the deceased from April 16
19 46 to May 10 19 46
that I last saw him or alive on May 10 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death
Pernicious anemia

Due to _____
Due to _____

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)
Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address 1515 Lafayette Avenue Date signed 5/10/46

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

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 Frank A. Moore

Licensed Embalmer No. 3041

P. O. Address 2117 E. Grand

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.