S. No. 2
M—2-43
. 5-17-39
P I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUN 26 1946

State File No. 21905

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5401

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Park Lane Memorial Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DEACESED:

(a) State Missouri (b) County Jefferson 50

(c) City or town ~~High Ridge~~ House Springs 0
(If outside city or town limits, write "RURAL")

(d) Street No. ~~Route #1~~ NR 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Clara Killes

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 Married

6. (b) Name of husband or wife John O.

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Aug. (Month) 16 (Day) 1877 (Year)

8. AGE: Years 68 Months 10 Days 0 If less than one day hr. min.

9. Birthplace Grand Tower (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Home

11. Industry or business

FATHER
12. Name Michael Schroer
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 9

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 9

16. (a) Informant John O. Killes
(b) Address Rt. #1 High Ridge, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/46 (Month) (Day) (Year)
(c) Place: burial or cremation New Picker Cemetery

18. (a) Signature of funeral director Wacker-Heidele
(b) Address 3634 Gravois Ave.

19. (a) JUN 18 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16 year 1946 hour 12 minute 45P. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of left hip, Arteriosclerosis; when she slipped and fell to the wooden floor in her home House Springs, Mo., on May 24, 1946, about 6:00 A.M. ACCIDENT — Duration

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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

22. If death was due to external causes, fill in the following: 50

(a) Accident, suicide, or homicide (specify) ACCIDENT

(b) Date of occurrence 5-24-46

(c) Where did injury occur? House Springs, Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home (Specify type of place)

While at work? (e) Means of injury

23. Signature Albert Berry (M.D. or other) 3

Address Date signed 6/18/46

(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 Robert. Wheeler

Licensed Embalmer No. 2128

P. O. Address St Louis Mo

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.