

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I-X38671

FILED JUN 5 1947
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5209**

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

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Barnes Hospital, D
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 days Specify whether years, months or days

In this community 7 days

3. (a) PRINT FULL NAME Martha Emma Klein

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female **5. Color or race** White

6. (a) Single, widowed, married, divorced, Wid. 2

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased June 21 1876
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>70</u>	<u>11</u>	<u>4</u>	hr. _____ min.

9. Birthplace Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation House Work

11. Industry or business _____

12. Name Not Known 4

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

14. Maiden name Not Known 11

15. Birthplace Germany 7
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Alfrida Klein

(b) Address Vincense. Ind

17. (a) Removal _____ **(b) Date thereof** May 26
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Vincense, Ind

18. (a) Signature of funeral director Math. Hermann & Son.
2161 E. Fair, Ave

(b) Address _____

19. (a) MAY 26 1947 **(b) J. F. Bredenk**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Indiana **(b) County** 999
100

(c) City or town Vincennes
(If outside city or town limits, write "RURAL")

(d) Street No. N.R. (If rural, give location) 2

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 25
 year 47 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from 5-19-47
 _____, 19 5/25/1947, 19 _____

that I last saw her alive on 5-25-47, 19 _____
 and that death occurred on the date and hour stated above.

Immediate cause of death cardiac failure Duration 1/2 hr

Due to arterio-sclerotic CVS disease

Due to _____

Other conditions diabetes mellitus
(Include pregnancy within 3 months of death)

Major findings: 6/1

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:

(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? _____

(e) Means of injury D.
(Specify type of place)

23. Signature J. F. Perry (M. D. or other)

Address Barnes Hospital 1110 Holt Perry Date signed _____

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.....

Licensed Embalmer No. 4292.....

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.