

No. 2  
12-45  
17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUL 26 1947  
Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25734  
Registrar's No. 5718

Primary Registration District No.

1. PLACE OF DEATH:  
(a) County  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
5126 St. Louis Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6 5126 St. Louis Avenue,  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARY KLEVORN  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 15th  
year 1947 hour 8:45 A.M. minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from June 17-47 to  
July 15th 1947  
that I last saw her alive on July 11th 1947  
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife GEORGE KLEVORN  
6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased February 19th 1888  
(Month) (Day) (Year)

Immediate cause of death Coronary arterio sclerosis  
Duration Unable to say.

8. AGE: Years Months Days If less than one day  
59 4 26 hr. min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions Diabetes Mellitus  
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Thomas Hayes  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Dowd  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. George Klevorn - Husband,  
(b) Address 5126 St. Louis Avenue,

17. (a) burial (b) Date thereof 7-18-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Calvary Cemetery

18. (a) Signature of funeral director Sullivan Brothers,  
(b) Address 2849 North Euclid Avenue,

19. (a) Jul 17 1947 (b) J. Bredeek  
(Date and local registrar) (Registrar's signature)

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) (c) Means of injury \_\_\_\_\_

23. Signature Peter A. Cook M.D. (M. D. or other)  
Address 4701 St. Louis Ave. Date signed \_\_\_\_\_

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

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

Dr. Eck,

Marcus & St. Louis Ave.

Ev. 6756 after 6<sup>00</sup> P.M.

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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

*Robert L. Brinkman*

Licensed Embalmer No. 3563

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.