

SEP 13 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

1003

State File No. **27906**
Registrar's No. **7555**

Registration District No.

Primary Registration District No.

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:
Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 MO.** (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **GARY V. Kleisshe**
3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex **MALE** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **S**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **July 11 1947** (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 1 17 hr. min.

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

10. Usual occupation **NIL**

11. Industry or business.....

12. Name **VINCENT Kleisshe**
13. Birthplace **St Louis MO** (City, town, or county) (State or foreign country)
14. Maiden name **Isabella Shippy**
15. Birthplace **St Louis MO** (City, town, or county) (State or foreign country)

16. (a) Informant **Vincent Kleisshe**
(b) Address **9010 North Overland MO**
17. (a) **Burial** (b) Date thereof **8/30/48** (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cem**

18. (a) Signature of funeral director **John F. Horne**
(b) Address **9222 Larchwood Overland MO**
19. (a) **AUG 28 1948** (Date received local registrar) (b) **J. F. Horne** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **ST LOUIS**
(c) City or town **OVERLAND** **96**
(If outside city or town limits, write "RURAL")
(d) Street No. **9010 North Ave** **13**
N.R. (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUG** day **28**
year **1948** hour **8:55** minute **00** A.M.
21. I hereby certify that I attended the deceased from **3/5/48**
to **8/28/48** 19 **48**
that I last saw him alive on **8/28** 19 **48**
and that death occurred on the date and hour stated above.
Duration
Immediate cause of death.....

Uremia
Chronic Pyelonephritis (Piles) ± 13 mo
Due to **Congenital Kidney**
Due to **Obstruction** **Block**

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

Major findings:
Of operations.....

Of autopsy **As Above +**
Partial Dissection of Liver

22. If death was due to external causes, all 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?..... (Specify type of place)

While at work?..... (e) Means of injury.....
23. Signature **Alvin Proctor** (M.D. or other) **MD**
Address **96 S. Broadway** Date signed **8/28**

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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.....

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.