

No. 2
5-43
5-17-39
X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41911
State File No. 11043
Registrar's No.

FILED JAN 11 1949 318

1003

Registration District No. Primary Registration District No.

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:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether
In this community life
years, months or days)

3. (a) PRINT FULL NAME August Von Cloedt
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M. (D) 5. Color or race W. 6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Rose R. Glaser 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased Feb. 9, 1888
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
/ 60 10 11 hr. min.

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

10. Usual occupation Night Foreman

11. Industry or business Ward Baking Company

MOTHER FATHER { 12. Name Julius Von Cloedt
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Maria Bongartz
15. Birthplace France
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rose Von Cloedt
(b) Address 4573 Audubon

17. (a) Cremation (b) Date thereof 12-23-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Alexander Bone
(b) Address 6175 Delmar

19. (a) DEC 21 1948 (b) J. B. Lester
(Date received) (Registrar's signature)

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. 4573 Audubon
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 20
year 1948 hour 5: minute 00 P.M.

21. I hereby certify that I attended the deceased from Oct. 28 to Dec. 20, 1948
that I last saw him alive on Dec. 20, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure
Due to Metastatic carcinoma 3 mos

Due to Adeno carcinoma of colon
Other conditions (include pregnancy within 3 months of death) H0

Major findings: Of operations H0
Of autopsy Colicarcinomatous
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?

23. Signature R. P. Beasley (Specify type of place) 8
Address 3902 Olive St (e) Means of injury.....
Date signed 12-21-48

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

Wahl Bildg
Vanit. Ch. Line
F H Bailey

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 Thomas R Fenwick

Licensed Embalmer No. 3793

P. O. Address 6175 Delmar

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.