

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42004

FILED DEC 31 1948

Registration District No. 377

Primary Registration District No. 3068

Registrar's No. 2824

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

35

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
7223 Lyndover Pl.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Maplewood 5  
(If outside city or town limits, write "RURAL") 3

(d) Street No. 7223 Lyndover Pl.  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Christine E. Klinger

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 4  
year 1948 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from Aug 1948  
\_\_\_\_\_, 19\_\_\_\_, to Dec 4, 19\_\_\_\_.

that I last saw her alive on Nov 30, 19\_\_\_\_  
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 Wm. C.H. Klinger 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased: April 27, 1877  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Stroke

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>7</u>	<u>7</u>	hr. _____ min. _____

Due to Cerebral Arterio Sclerosis Years

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

Due to 430

10. Usual occupation Housewife

Other conditions Previous Cerebral Hemorrhage  
(Include pregnancy within 3 months of death) Aug 1948

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

Major findings: None

12. Name William Grannemann

Of operations None

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

Of autopsy None

14. Maiden name Christine Wichmeyer

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

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

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

16. (a) Informant William Klinger

(a) Accident, suicide, or homicide (specify) no

(b) Address 7223 Lyndover Pl.

(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof 12-7-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(c) Place: burial or cremation St. Trinity Cemetery

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0

18. (a) Signature of funeral director Jay B. Smith

While at work? \_\_\_\_\_ (Specify type of place) (b) Means of injury \_\_\_\_\_

(b) Address 7456 Manchester Rd

33. Signature John A. [unclear] (M. D. or other) MD

19. (a) 12-7-48 (b) [unclear]  
(Date received local registrar) (Registrar's signature)

Address Maplewood Date signed 12/6/48

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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.....

*H. C. Burgess*

Licensed Embalmer No.....

*4129*

P. O. Address.....

*Maplewood*

**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.**