

FILED JUL 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20668

BIRTH NO. _____		REG. DIST. NO. <u>314</u>		PRIMARY REG. DIST. NO. <u>6006</u>		Registrar's No. <u>21</u>	
1. PLACE OF DEATH a. COUNTY <u>St Clair County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Clair</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Butler</u>		c. LENGTH OF STAY (in this place) <u>54 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lowry city</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) <u>Rural 2 Mile North 3 Miles West</u>			
3. NAME OF DECEASED (First) <u>Loise</u> (Middle) <u>Catherine</u> (Last) <u>Kalberloh</u>			4. DATE OF DEATH (Month) <u>June</u> (Day) <u>23</u> (Year) <u>1949</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 28 1861</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>26</u>	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Sindelfingen Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Jollies Jenisch</u>		13b. MOTHER'S MAIDEN NAME <u>Un Known</u>		14. NAME OF HUSBAND OR WIFE <u>Fred Kalberloh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Wallace Doty</u> ADDRESS <u>Lowry City</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Compound Fracture of Hip by fall.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 hrs</u> <u>9040</u> <u>20</u>	
19a. DATE OF OPERATION <u>May 10-49</u>	19b. MAJOR FINDINGS OF OPERATION <u>Compound Fracture of Rt Femur.</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN) OR TOWNSHIP (COUNTY) <u>Butler Co. St Clair Co.</u>		21d. (STATE) <u>Mo.</u>			
21d. TIME OF INJURY (Month) <u>May</u> (Day) <u>7</u> (Year) <u>49</u> (Hour) _____ (Min) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>By Fall</u>					
22. I hereby certify that I attended the deceased from <u>May 10, 1949</u> to <u>June 23, 1949</u> , that I last saw the deceased alive on <u>June 23, 1949</u> , and that death occurred at <u>4:55 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. D. J. Dorman M.D.</u>			23b. ADDRESS <u>Lowry City, Mo.</u>		23c. DATE SIGNED <u>6-24-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 25-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Valley Center</u>		24d. LOCATION (City, town, or county) (State) <u>Rural Lowry city Mo.</u>			
DATE REC'D BY LOCAL REG. <u>July 8-1949</u>	REGISTRAR'S SIGNATURE <u>Paul H. Seavers</u>	25. FUNERAL DIRECTOR'S SIGNATURE (ADDRESS) <u>Vernon C. Austin</u>	<u>Lowry city Mo.</u>				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No.

State No. Number 6-49-

Date Filed 7-8-49

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

Student Embalmer No.

working under my personal supervision.

Student Student Embalmer

Signed *J.B. Goodrich*

Licensed Embalmer No. 3038

P. O. Address *Crescent*

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.