

FILED FEB 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2685
State File No.
Registrar's No. 884

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 5952 Hamilton Terrace	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospt			

3. NAME OF DECEASED (Type or Print) George H. Klauberg			4. DATE OF DEATH Month Jan Day 26 Year 1950		
5. SEX Male	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug 12 1877	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Frederick Klauberg	13b. MOTHER'S MAIDEN NAME ? Jetter	14. NAME OF HUSBAND OR WIFE Elvina Klauberg
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. 492-09-4510	17. INFORMANT'S SIGNATURE OR NAME Elvina Klauberg	ADDRESS 5952 Hamilton Ter
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 mo
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio-sclerotic Cardiovascular disease DUE TO (c) Hypertension		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 443X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **May 1949** to **Jan 26**, 1950, that I last saw the deceased alive on **Jan 26**, 1950, and that death occurred at **10.45 AM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. C. N. Lindeman M.D.	23b. ADDRESS 4176 S. Shrew	23c. DATE SIGNED 1/27/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 30 1950	24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemt	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
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DATE REC'D BY LOCAL REG. JAN 27 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Jos. W. Clark	ADDRESS 1125 Hodiament Ave
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Linderman

4126 a Shreve Ave

12pm to 3.30 P.M.

Ev 7140

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 Guy W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St. Louis Mo.

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.