

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28370  
7458

State File No. ....  
Registrar's No. ....

FILED SEP 9 1950

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

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. ....			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>66 Yrs.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2179</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Deaconess Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>3223 Copelin Avenue</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Arthur</b>		b. (Middle) <b>G. O.</b>		c. (Last) <b>Klittich</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 30, 1950</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Mar. 8, 1884</b>		9. AGE (In years last birthday) <b>66</b> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sheet Metal Contr.</b>		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Ernst Klittich</b>			13b. MOTHER'S MAIDEN NAME <b>Wilhelmina Brockmeier</b>			14. NAME OF HUSBAND OR WIFE <b>Edna Schaub</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Edna Schaub, 3223 Copelin Avenue.</b>					
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) <b>Ruptured ventricle</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b>  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 <b>Sudden</b>  <b>Unknown</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <b>HHHX</b>					
22. I hereby certify that I attended the deceased from <b>8-15, 1950</b> , to <b>8-30, 1950</b> , that I last saw the deceased alive on <b>8-30, 1950</b> , and that death occurred at <b>1:30 p.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>Bert N. Klein</b> (Declarant title)				23b. ADDRESS <b>2637 S. Kingshighway</b>		23c. DATE SIGNED <b>8-31-50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Sept. 2, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Concordia Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>			
DATE REC'D BY LOCAL REG. <b>SEP 1 1950</b>				REGISTRAR'S SIGNATURE <b>J. B. Sasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>BEIDERWIEDEN F.H. INC., 1936 St. Louis, Mo.</b>			

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

Dr. Arnold Klein  
2632 So. Kingshighway

Mon. Tues. Thurs. Fri. 1:00 - 4:00

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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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed *Max L. Warfel*.....

Licensed Embalmer No. *4170*.....

P. O. Address *1936 St Louis Ave*.....

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.