

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **21292**  
Registrar's No. **5099**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1005</b>		Registrar's No. <b>5099</b>			
1. PLACE OF DEATH a. COUNTY <b>MISSOURI PACIFIC HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <b>MISSOURI</b> b. COUNTY <b>St. Louis</b>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) <b>41 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo. Afton</b>		<b>4820</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>MISSOURI PACIFIC HOSPITAL</b>				d. STREET ADDRESS (If rural, give location) <b>1801 TELEGRAPH ROAD.</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>ANNA.</b>		b. (Middle) <b>—</b>		c. (Last) <b>KLEIN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 2, 1951</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED. 1</b>		8. DATE OF BIRTH <b>MAY 26, 1886</b>			
9. AGE (In years last birthday) <b>65</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME.</b>		11. BIRTHPLACE (State or foreign country) <b>HUNGARY</b>			
12. CITIZEN OF WHAT COUNTRY? <b>Do. Not Know</b>		13a. FATHER'S NAME <b>JOHN GESTRICH</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>KARL KLEIN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>KARL KLEIN 639 W. ARLEE</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>Cachexia</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Fistulae of ileum and colon</b> DUE TO (c) <b>Intestinal obstruction</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Carcinoma of the cervix</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>Obstruction of the ileum; ulcer of ileum (necrosis)</b>				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.)		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>171X</b>					
22. I hereby certify that I attended the deceased from <b>4-23-</b> , 19 <b>51</b> , to <b>5-31-</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>5-31-</b> , 19 <b>51</b> , and that death occurred at <b>5:40 A.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Barth M. Passanante, M.D.</b>				23b. ADDRESS		23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>JUNE 4 1951</b>		24c. NAME OF CEMETERY OR CREMATORY <b>SUNSET BURIAL</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>			
DATE RECORDED BY LOCAL REG. <b>JUN 5 1951</b>		REGISTRAR'S SIGNATURE <b>J. B. Forster</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Thomas Kulis 2906 Gravois</b>					

(Licensed Embalmer's Statement on Reverse Side)

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

**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 Leo J. Budde

Signed.....  
Student Embalmer

Licensed Embalmer No. 3989

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.