

FILED JUL 26 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24863  
6173

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <b>348</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. ....	
1. PLACE OF DEATH a. COUNTY <b>1</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</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) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2149</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5343 Neosho St.</b>				11. STREET ADDRESS (If rural, give location) <b>5343 Neosho St.</b>			
3. NAME OF DECEASED (Type or Print) <b>MARY</b>		a. (First) _____		b. (Middle) <b>G.</b>		c. (Last) <b>KLEIER</b>	
4. DATE OF DEATH <b>July 8 1951</b>		(Month) _____ (Day) <b>8</b> (Year) <b>1951</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Nov. 27, 1872</b>		9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months _____ Days _____	
IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <b>Aviston, Ill.</b>				12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME <b>John Heidel</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>John Kleier</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>John Kleier</b> ADDRESS <b>5343 Neosho St.</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral apoplexy</b> ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>4 yrs +</b>	
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>No</b>		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) _____ (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>33HX</b>			
22. I hereby certify that I attended the deceased from <b>Sept. 1877</b> , to <b>July 8, 1951</b> , that I last saw the deceased alive on <b>July 8, 1951</b> , and that death occurred at <b>3:10 P. M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Bernard T. Koon M.D.</b>				23b. ADDRESS <b>4755 Maryland Rd. St. Louis 16, Mo.</b> DATE SIGNED <b>July 9, 1951</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>July 11, 1951</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>		24d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b> (State) _____	
DATE REC'D BY LOCAL REG. <b>JUL 10 1951</b>		REGISTRAR'S SIGNATURE <b>J. B. Jasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Kriegshauser 4228 S. Kingshighway Bl.</b>			

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

42552 Morganford  
1-4-1911

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 William B. White

Signed.....  
Student Embalmer

Licensed Embalmer No. 4291

P. O. Address 4228 So Kingshighway

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.