

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 12 1952

State File No.

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

BIRTH NO.		REG. DIST. NO. 317	PRIMARY REG. DIST. NO. 3063	Registrar's No. 137
1. PLACE OF DEATH a. COUNTY ST. LOUIS		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 township) OR TOWN ST. LOUIS COUNTY Hosp.		c. LENGTH OF STAY (in this place) 5 HRS		
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS COUNTY Hosp.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Heights 4525		
3. NAME OF DECEASED (Type or Print) KLINCAR		d. STREET ADDRESS (If rural, give location) 2019 Big Bend Blvd. OK		
a. (First)		b. (Middle)		c. (Last) PAUL
4. DATE OF DEATH (Month) (Day) (Year) 1 17 52		5. SEX MALE		
6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH MAY-1-1888
9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UPHOLSTER	11. BIRTHPLACE (State or foreign country) ST. LOUIS MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME PAUL KLINCAR		13b. MOTHER'S MAIDEN NAME CAROLINE		14. NAME OF HUSBAND OR WIFE ADA KLINCAR
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 1ST 4-25-18 TO 6-26-19		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME ADDRESS ADA KLINCAR - 2019 Big Bend
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 hours
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		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) 331X
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?
22. I hereby certify that I attended the deceased from 1-17, 1952 to 1-17, 1952 that I last saw the deceased alive on 1-17, 1952 and that death occurred at 8:25 AM , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) Robert H. DeBolt M.D.		23b. ADDRESS 601 S. Brentwood Clayton		23c. DATE SIGNED 1-17-52
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 1-19-52		24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY
24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JAY B SMITH FUNERAL HOME 7406 MANCHESTER-MITCHELWOOD MO		
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		

2021 QW

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 *J.P. Burgess*

Signed.....
Student Embalmer

Licensed Embalmer No. *4029*

P. O. Address *Maplewood*

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.