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FILED MAY 18 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19582
State File No. 4600
Registrar's No. 4600

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 MO b. COUNTY ST. LOUIS	
b. CITY OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WEBSTER GROVES 4607	
d. FULL NAME OF HOSPITAL OR INSTITUTION MO. PACIFIC HOSPITAL		d. STREET ADDRESS (If rural, give location) 500 GRAY AVE	

3. NAME OF DECEASED (Type or Print) BEATRICE ELEANOR KLAUSS			4. DATE OF DEATH MAY 5-1953		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year

5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED SINGLE	8. DATE OF BIRTH MAY 24-1906	9. AGE (In years last birthday) 46	10 UNDER 1 YEAR	11 UNDER 1 HR.
					Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PATH. TECHNICIAN	10b. KIND OF BUSINESS OR INDUSTRY MO. PAC. HOSP.	11. BIRTHPLACE (City and State or Foreign Country) CRAFTON PENN	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME W ^M GEO. KLAUSS	13b. MOTHER'S MAIDEN NAME JANET LAURIE JOHNSTON	14. NAME OF HUSBAND OR WIFE NONE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME S.S. Baker 500 Gray.	ADDRESS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cyanide Poisoning, self administered at Missouri Pacific Hospital, May 4th 1953 about 11:30 pm		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Taciee Hospital, May 4th 1953 about 11:30 pm		
	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 Suicide	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Shop	21c. (CITY, TOWN, OR TOWNSHIP), (COUNTY) (STATE) St. Louis Mo
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21d. TIME OF INJURY May 4 5:30 pm	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR E9718
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:37 A. M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Patrick E. Doyle 3	23b. ADDRESS 1300 Olive	23c. DATE SIGNED 5/6/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 5-7-53	24c. NAME OF CEMETERY OR CREMATORY VALHALLA CREMATORY	24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo.
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DATE REC'D BY LOCAL REG. MAY 6 1953	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE M. O. Parker - Aldrich F. Home Webster Groves Mo.	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Leslie Welch* _____

Licensed Embalmer No. *4395* _____

P. O. Address *Whater Ground* _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.