

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

22958

FILED JUN 24 1953

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5775**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN ST. LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION FIRMIN DESLOGE		e. STREET ADDRESS (If rural, give location) 17 3454 PARK AV. 2179	

3. NAME OF DECEASED (Type or Print) ROSE KLEINSCHMIDT.			4. DATE OF DEATH (Month) (Day) (Year) JUNE 8-53		
a. (First)	b. (Middle)		c. (Last)	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
FE	W	W	W	MARCH-22-1874	79 YRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY OWN		11. BIRTHPLACE (City and State or Foreign Country) Chillicothe Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME CHARLES WILMS		13b. MOTHER'S MAIDEN NAME KATHERINE DOERSAM		14. NAME OF HUSBAND OR WIFE HERMAN KLEINSCHMIDT	
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.		17. INFORMANT'S SIGNATURE OR NAME Maud M. INGLES	
				ADDRESS 3454 PARK AV.	

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) arteriosclerotic heart disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Gen Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH undef. undef. 1-2 days
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. uremia				

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)	

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? 4200	
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22. I hereby certify that I attended the deceased from March, 1953, to 6/8/53, 19___, that I last saw the deceased alive on 6/8/53, 19___, and that death occurred at 1:00 P. M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>L. C. Smith</i>		23b. ADDRESS <i>16 Hampton Valley Plaza</i>		23c. DATE SIGNED <u>6/9/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE <u>JUNE-12-53</u>		24c. NAME OF CEMETERY <u>BETHANIA CEM.</u>	
				24d. LOCATION (City, town, or county) (State) ST LOUIS MO.	

DATE REC'D BY LOCAL REG. <u>JUN 10 1953</u>		REGISTRAR'S SIGNATURE <i>J. C. Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. SEHNUR 31254 AFAYETTE	
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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
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....



Licensed Embalmer No. 4

P. O. Address 3125 2nd

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.