

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30134

State File No. _____

FILED AUG 20 1953

7233

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
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 (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Bernard Nurseing Home				e. STREET ADDRESS (If rural, give location) 5 6220 Northwood					
3. NAME OF DECEASED (Type or Print) a. (First) MORRIS b. (Middle) DAVID c. (Last) KLEIN			4. DATE OF DEATH July 24, 1953						
5. SEX male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Nov, 28, 1874			
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Millinery		11. BIRTHPLACE (City and State or Foreign Country) New York State 1		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Herman Klein			13b. MOTHER'S MAIDEN NAME (?) Klein (not related)		14. NAME OF HUSBAND OR WIFE Hilda Harris Klein				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 407-01-6901		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Samuel Klein #4 Wood Clif Rd.					
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 DUE TO (b) Congestive Heart Failure DUE TO (c) Cerebral Thrombosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND 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) 420.0					
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?					
22. I hereby certify that I attended the deceased from Dec. 1947 , to July 24, 1953 , that I last saw the deceased alive on July 23, 1953 , and that death occurred at 6 A. m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Julius Olson, M.D.				23b. ADDRESS 607 N. Grand		23c. DATE SIGNED 7/24/53			
24a. BURIAL OR CREMATION REMOVAL (Specify) Interment		24b. DATE 7/26/53		24c. NAME OF CEMETERY OR CREMATORY B. Nai Amoona		24d. LOCATION (City, town, or county) (State) .N.N.& SOUTH ROAD (State)			
DATE REC'D BY LOCAL REG. JUL 25 1953		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mayer 4356 Lindell Blvd					

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, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Robert M. Murray*.....

Licensed Embalmer No. *37491*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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