

U. S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE  
STANDARD CERTIFICATE OF DEATH

34524

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 2927

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>		c. LENGTH OF STAY (in this place) <u>14 DAYS</u>	c. CITY OR TOWN <u>Clayton</u> <u>442</u> <u>1</u>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Mary's Hosp.</u>		e. STREET ADDRESS (If rural, give location) <u>8070 Watkins Dr.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Richard</u>	b. (Middle) <u>Joseph</u>	c. (Last) <u>Klohr</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 11. 1953</u>
--	---------------------------	------------------------	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 21. 1883</u>	9. AGE (in years) (last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days	IF UNDER 18 HRS. Hours Min.
--------------------	-------------------------------	---	---------------------------------------	---	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Housing Adm.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Damiansville, Ill</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	--	---	---

13a. FATHER'S NAME <u>John Klohr</u>	13b. MOTHER'S MAIDEN NAME <u>Carolyn Voelker</u>	14. NAME OF HUSBAND OR WIFE <u>Nell Klohr</u>
--------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Red. Employee</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Nell Klohr</u>	ADDRESS <u>8070 Watkins Dr.</u>
--	--	---	---------------------------------

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) <u>Carcinoma of prostate with bone metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>		<u>None</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	19c. 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) <u>177X</u>
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 Sept. 10, 1948, to 9/11, 1953, that I last saw the deceased alive on 9/11, 1953, and that death occurred at 10:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree of title) <u>Thomas C. Andrade M.D.</u>	23b. ADDRESS <u>4660 Monroeville</u>	23c. DATE SIGNED <u>9/12/53</u>
---	---	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Sept 14, 53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
---	---------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>9/12/53</u>	REGISTRAR'S SIGNATURE <u>Robert E. Sprinkle, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Stock</u>	ADDRESS <u>2117 E. Grand Ave.</u>
--	--	--	--------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

DR. THOMAS BIRDSALL  
4660 MARYLAND  
RO 6074

---

---

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.....

*J. W. Bentley*

Licensed Embalmer No. *7653*

P. O. Address *St. Louis, Mo.*

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.