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FILED MAR 15 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6428**  
**2083**

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 <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>	c. LENGTH OF STAY (in this place) <b>73 yrs</b>	c. CITY OR TOWN <b>St. Louis</b>	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: <b>St. Anthony Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>4266 Meramec Street</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>EDMUND</b> b. (Middle) <b>H.</b> c. (Last) <b>KLEIST</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Mar. 4, 1954</b>							
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widower</b>	8. DATE OF BIRTH <b>Aug. 18, 1880</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired druggist</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>retail druggist</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>	12. CITIZENRY OF WHAT COUNTRY? <b>USA</b>					

13a. FATHER'S NAME <b>Carl Kleist</b>	13b. MOTHER'S MAIDEN NAME <b>Louise Rotten</b>	14. NAME OF HUSBAND OR WIFE <b>Emma Hartmann Kleist</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mr. Vernon C. Kleist</b>	ADDRESS <b>4266 Meramec St.</b>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Infarction</b>		<b>3 days</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Atherosclerosis General</b> <b>Atherosclerotic Heart Disease</b> DUE TO (c)		<b>unk</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>unk</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4200</b>
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22. I hereby certify that I attended the deceased from **5/11**, 19**53**, to **2/4**, 19**54**, that I last saw the deceased alive on **3/4**, 19**54**, and that death occurred at **4:30 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Robert S Warner MD</b>	23b. ADDRESS <b>Paul Brown Bldg #12</b>	23c. DATE SIGNED <b>3/5/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Mar. 6, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>MAR 6 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Feiderwieden F.H. Inc.</b>	ADDRESS <b>1936 St. Louis Ave.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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. None working under my personal supervision..

Student None Signature of Student Embalmer

Signed Delis J. Krispin

Licensed Embalmer No. 34

P. O. Address St. Lou

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.