

FILED APR 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13669

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2954

1. PLACE OF DEATH a. COUNTY		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>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Overland 427 X</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christian Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>8005 Nola</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Minnie</u> b. (Middle) c. (Last) <u>Kluesner</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 30, 1954</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 15, 1890</u>
9. AGE (In years last birthday) <u>64</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>St. Charles County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>John D. Koch</u>	
13b. MOTHER'S MAIDEN NAME <u>Julia Krue</u>		14. NAME OF HUSBAND OR WIFE <u>William Kluesner</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.	
17. INFORMANT'S SIGNATURE OR NAME <u>William Kluesner</u>		ADDRESS <u>8005 Nola</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chl. myocarditis</u>			
DUE TO (c) <u>—</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>—</u>			
19a. DATE OF OPERATION <u>—</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>— 420.1</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>1951</u> , 19___, to <u>3/30/54</u> , 19___, that I last saw the deceased alive on <u>3/12/54</u> , 19___, and that death occurred at <u>5 P.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>[Signature]</u>		23b. ADDRESS <u>6917 W. Florissant</u>	23c. DATE SIGNED <u>4/1/54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Apr. 2, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Garden</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
DATE REC'D BY LOCAL REG. <u>APR 1 1954</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ortmann F. Home</u>	
		ADDRESS <u>9222 Lackland</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING FADING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed..... *Al C Ortmann*

Signed.....
Student Embalmer

Licensed Embalmer No. *3478*

P. O. Address.....

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.