

FILED MAY 17 1954

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

State File No. **17196**  
Registrar's No. **4167**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>4167</b>	
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</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bernard Nursing Home</b>				d. STREET ADDRESS (If rural, give location) <b>4165 Magnolia Av.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>WILLIAM</b>		b. (Middle) <b>C.</b>		c. (Last) <b>KLEINE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>May 7, 1954</b>	
5. SEX <input checked="" type="radio"/> Male		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Feb. 13, 1867</b>	
9. AGE (In years last birthday) <b>87</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>orthopedist</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Osnabrueck, Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <b>orthopedic</b>		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>Conrad Kleine</b>			13b. MOTHER'S MAIDEN NAME <b>Margarethe Klages</b>			14. NAME OF HUSBAND OR WIFE <b>Anna C. Desebrock</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Margaret Gerboth</b> ADDRESS <b>4165 Magnolia Ave</b>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease</b> ANTECEDENT CAUSES <b>generalized arteriosclerosis</b> Morbidity 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.				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>2 yrs.</b>	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4200</b>			
22. I hereby certify that I attended the deceased from <b>June 1, 1952</b> , to <b>May 7, 1954</b> , that I last saw the deceased alive on <b>May 7, 1954</b> , and that death occurred at <b>4:15 P. m.</b> , from the causes and on the date stated above.							
SIGNATURE (Deceased or title) <b>James P. Murphy, M.D.</b>				23b. ADDRESS <b>1607 N. Grand Blvd.</b>		23c. DATE SIGNED <b>5-7-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		24b. DATE <b>May 10, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>MAY 10 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Belderwieden F.H. Inc.</b> ADDRESS <b>1936 St. Louis Ave.</b>			

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

(Licensed Embalmer's Statement on Reverse Side)

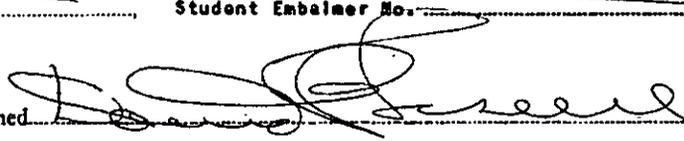
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

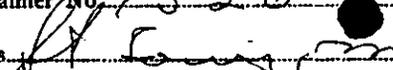
Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 4520

P. O. Address  \_\_\_\_\_

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