

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5893

FILED MAR 14 1955

State File No.

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 68

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u> <u>0</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>ST. CHARLES</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. CHARLES</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>O'FALLON</u> <u>0920</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>— — — — —</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. GABRIEL Hospital.</u>			

3. NAME OF DECEASED (Type or Print) <u>AURELIA</u>	a. (First)	b. (Middle) <u>—</u>	c. (Last) <u>KLEESCHULTE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 1 1955</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>JUNE 28 1891</u>	9. AGE (In years last birthday) <u>64</u> <u>8</u> <u>1</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>	11. BIRTHPLACE (State or foreign country) <u>ST. CHARLES Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>STAHL SCHMIT</u>	13b. MOTHER'S MAIDEN NAME <u>TURNBOLT</u>	14. NAME OF HUSBAND OR WIFE <u>CLEM KLEESCHULTE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>CLEM KLEESCHULTE O'FALLON</u>	ADDRESS <u>Mo</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 Min.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Obesity & Hepatic Cirrhosis</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4201</u>	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) <u>O'FALLON Mo</u>
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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?
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22. I hereby certify that I attended the deceased from Sept 1954 to 1 MAR 1955, that I last saw the deceased alive on 28 Feb 1955, and that death occurred at 6:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Cene J. DuMontier M.D. O</u>	23b. ADDRESS <u>O'Fallon Mo.</u>	23c. DATE SIGNED <u>4 MAR 55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>MAR 5 1955</u>	24c. NAME OF CEMETERY OR CREMATORIUM <u>ASSUMPTION</u>	24d. LOCATION (City, town, or county) (State) <u>O'FALLON Mo</u>
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DATE REC'D BY LOCAL REG. <u>March 5 1955</u>	REGISTRAR'S SIGNATURE <u>Russell Hamilton</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ed K. Kelly</u>	ADDRESS <u>O'Fallon Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 14 1955

MAR 14 1955

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

E. Keithly

Licensed Embalmer No. _____

872

P. O. Address _____

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