

FILED SEP 26 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32172**  
Registrar's No. **8131**

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. 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 town) <b>Deaconess Hospital</b>		c. LENGTH OF STAY (In this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) <b>ST. LOUIS</b>		d. STREET ADDRESS (If rural, give location) <b>4737 GREER AVE</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>DEACONESS HOSPITAL</b>								
3. NAME OF DECEASED (Type or Print) a. (First) <b>Johanna</b>		b. (Middle) <b>Kleynas</b>		c. (Last) _____				
4. DATE OF DEATH (Month) (Day) (Year) <b>SEPT 18 1956</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>				
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>12-20-1885</b>		9. AGE (In years last birthday) <b>70</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>LITHUANIA</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U-S-A</b>		13a. FATHER'S NAME <b>GEORGE MIKALAWSKI</b>		13b. MOTHER'S MAIDEN NAME <b>URSULA POSIUS</b>				
14. NAME OF HUSBAND OR WIFE <b>JOSEPH KLEYUNAS (DECD)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>				
17. INFORMANT'S SIGNATURE OR NAME <b>JULIA KLEYUNAS</b>		17. ADDRESS <b>4737 GREER 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, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Aortic stenosis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Calcification of aortic valve</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>421.1</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years 6+</b>		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input 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? _____				
22. I hereby certify that I attended the deceased from <b>Oct. 1952 to Sept. 1, 1956</b> , that I last saw the deceased alive on <b>Sept. 31, 1956</b> , and that death occurred at <b>7:40 A. M.</b> , from the causes and on the date stated above.								
22a. SIGNATURE <b>Jirkle Cok</b>		22b. ADDRESS <b>M.R. 508 N. Grand Blvd.</b>		22c. DATE SIGNED <b>Sept 11, 56</b>				
23a. BURLIAL, CREMATION, REMOVAL (Specify) <b>BURLIAL</b>		23b. DATE <b>SEPT. 4-1956</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>				
23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>		24. DATE REC'D. BY LOCAL REG. <b>SEP 4 1956</b>		24. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>				
25. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas Kutia</b>		25. ADDRESS <b>2906 GRAYIS</b>						

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

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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 .....  
Student Embalmer

Student Embalmer No. ....  
Signed *Samuel Hill*

Licensed Embalmer No. *43471*

P. O. Address *2906 Spruce* (Fa)

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.