

FILED SEP 27 1956

BIRTH NO. _____ REG. DIST. NO. **312** PRIMARY REG. DIST. NO. **544** Registrar's No. **2118**

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

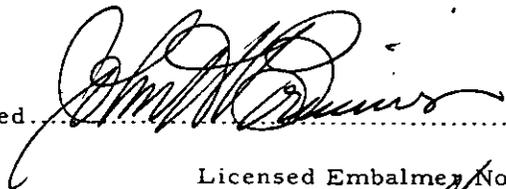
1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY JEFFERSON	
b. CITY OR TOWN KIRKWOOD		c. CITY OR TOWN HOUSE SPRINGS	
c. LENGTH OF STAY (in this place) 1 DAY		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST JOSEPHS HOSPITAL		e. STREET ADDRESS (If rural, give location) RR#2 05001	
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) ANTON c. (Last) KLEY		4. DATE OF DEATH (Month) (Day) (Year) SEPT. 7 1956	
5. SEX M.	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DEC. 15 1896
9. AGE (In years last birthday) 59		10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (City and State or Foreign Country) ST LOUIS MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME WILLIAM J. KLEY		13b. MOTHER'S MAIDEN NAME SOPHIA FUERST	
14. NAME OF HUSBAND OR WIFE LILLIAN KLEY (SMYTHE)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES NO W.W.#1	
16. SOCIAL SECURITY NO. unk.		17. INFORMANT'S SIGNATURE OR NAME William M. Kley - House Springs RR#2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. INTERVAL BETWEEN ONSET AND DEATH 6 hours	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		MEDICAL CERTIFICATION	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b) Hypertensive Vascular Disease		DUE TO (c) None	
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)			
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) 3314	
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?			
22. I hereby certify that I attended the deceased from Sept 7 1956 , to Sept 7 1956 , that I last saw the deceased alive on Sept 7 1956 , and that death occurred at 5:01 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Frank Kalamoros MD		23b. ADDRESS 206 N. Clay, Kirkwood Mo	
23c. DATE SIGNED 9/8/56			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 9/10/1956	
24c. NAME OF CEMETERY OR CREMATORY ST. MARTINS CEM.		24d. LOCATION (City, town, or county) (State) HIGH RIDGE MO	
DATE REC'D BY LOCAL REG. 9-8-56		REGISTRAR'S SIGNATURE Herbert R. Donk MD	
25. FUNERAL DIRECTOR'S SIGNATURE BRUNNER FUNERAL HOME		ADDRESS HOUSE SPRINGS MO	

10/1/2
1922

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.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No. 147
P. O. Address *House Spring*

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.