Health, & Welfare Public Service

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED APR 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 10550

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2668

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony's — Length of stay in 1b 9	d. STREET ADDRESS (If outside, give location) 5626 Fyler Ave. — Reside on Farm Yes ☐ No ☐

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3. NAME OF DECEASED (Type or print) First: Ida Middle: B. Last: Klickermann			4. DATE OF DEATH Month Day Year: March 16th 1957
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 10-29-1879 — 9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Cuba, Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Nowack		14. MOTHER'S MAIDEN NAME: Bertha Haack	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None		16. SOCIAL SECURITY NO.: None	17. INFORMANT Address: Olga Klickermann 5626 Fyler Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Chr. myocarditis — ?

DUE TO (c) Hypostatic pneumonia — 8 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year	422.2	
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Feb. 20 1957 to March 16 1957 and last saw her/him alive on 3/16/57

Death occurred at 10 00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): W. F. Heim, M.D.	22b. ADDRESS: 5203 Chippewa St.	22c. DATE SIGNED: 3/18/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Mar. 19, 1957	23c. NAME OF CEMETERY OR CREMATORY: New St. Marcus Cem.	23d. LOCATION (City, town, or county) (State): St. Louis, Mo.
24. FUNERAL DIRECTOR ADDRESS: Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG.: MAR 18 '57	26. REGISTRAR'S SIGNATURE: J. Carl Smith MD

(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 emb

by me, or by ..... Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 45

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.