

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 1 - 1957

1003 State File No. 14904
Registrar's No. 3550

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).		
b. CITY (If outside corporate limits, write RURAL and give township) ST LOUIS			c. LENGTH OF STAY (in this place) 5 DAYS	c. CITY OR TOWN 4001 FLORISSANT	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 09 DE PAUL HOSPITAL			e. STREET ADDRESS (If rural, give location) 27 930 LINDSAY LANG		
3. NAME OF DECEASED (Type or Print)		a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALBERT J. KLOER					APRIL 11, 1957
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG. 12, 1877	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE	10b. KIND OF BUSINESS OR INDUSTRY LUMBER	11. BIRTHPLACE (City and State or Foreign Country) ILLINOIS	12. CITIZEN OF WHAT COUNTRY? USA.	13a. FATHER'S NAME JOSEPH KLOER	13b. MOTHER'S MAIDEN NAME LOUISE HEMMER
14. NAME OF HUSBAND OR WIFE MARY W. KLOER	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 488-09-6242	17. INFORMANT'S SIGNATURE OR NAME ROBERT W. KLOER	ADDRESS 149 N. ELIZABETH FERGUSON, MO.	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.
					19. DATE OF OPERATION
					19b. MAJOR FINDINGS OF OPERATION 450.0
					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) (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 Aug 24, 1956, to April 11, 1957, that I last saw the deceased alive on April 11, 1957, and that death occurred at 3 P. m., from the causes and on the date stated above.					
23a. SIGNATURE W.D. Bishop			23b. ADDRESS 751 ST FRANCOIS ST	23c. DATE SIGNED April 12, 1957	23d. NAME OF CEMETERY OR CREMATORY CALVARY
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4-15-1957	24c. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI	24d. DATE REC'D BY LOCAL HEALTH DEPT. APR 15 57	REGISTRAR'S SIGNATURE Gene Whitcomb	25. FUNERAL DIRECTOR'S SIGNATURE Gene Whitcomb
					ADDRESS FLORISSANT, MO

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

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..... *Gene A. Hutchens*

Licensed Embalmer No..... *4966*

P. O. Address..... *Flouissant*

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.