

FILED AUG 7 1957

STANDARD CERTIFICATE OF DEATH

State File No. 27043

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 500		Registrar's No. 1799				
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give township) Lemay		c. LENGTH OF STAY (in this place) 2 yrs		c. CITY OR TOWN St. Louis		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 Lemay Nursing Home				e. STREET ADDRESS (If rural, give location) 3911 Jamieson Ave						
3. NAME OF DECEASED (Type or Print) HEMINA			a. (First)		b. (Middle)		c. (Last) KLOCKZIN			
4. DATE OF DEATH 7-17-1957		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH 6-1-1871		
9. AGE (In years last birthday) 86		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and State or Foreign Country) Germany		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME John Heinen			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Deceased				
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. None			17. INFORMANT'S SIGNATURE OR NAME Helda Proeder			ADDRESS 3911 Jamieson Ave	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis						INTERVAL BETWEEN ONSET AND DEATH 2 days		
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio-sclerotic heart disease						2 yrs		
		DUE TO (c) _____								
		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 type="checkbox"/> NO <input checked="" 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)		4200				
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 7-14-1957 , to 7-17-1957 , that I last saw the deceased alive on 7-17-1957 , and that death occurred at 1:20 P.m. , from the causes and on the date stated above.										
23a. SIGNATURE George A. O'Sullivan, M.D.				23b. ADDRESS 7629 Ivory Ave.				23c. DATE SIGNED 7-18-57		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-20-1957		24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery		24d. LOCATION (City, town, or county) (State) 4260 Bates St. Mo.				
DATE REC'D BY LOCAL REG. 7/18/57		REGISTRAR'S SIGNATURE Norbert A. Donk		25. FUNERAL DIRECTOR'S SIGNATURE Ziegler Bros		ADDRESS 6409 Gravois Ave				

(Licensed Embalmer's Statement (or Reverse Side))

Dr. O'Sullivan 7629 Ivory Ave
PL 2-1242 Ex. 163
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD. 7629

EMBALMER

CERTIFICATE

STATE

NO.

DATE

TIME

BY

NAME

ADDRESS

OF

CITY

STATE

COUNTY

ZIP

BY

NAME

ADDRESS

DATE

TIME

BY

NAME

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 *Jan M. Simon*

Licensed Embalmer No. 4343

P. O. Address *St. Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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