

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

47588

STATE FILE NUMBER

FILED JAN 27 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12273

V. S. 300  
Rev. 1-57

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>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Clayton</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		Length of stay in lb <b>12 days</b>	d. STREET ADDRESS (If outside, give location) <b>27 21 Seminary Terrace</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>GEORGE</b> Last <b>KLINCK</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>19,</b> Year <b>1957</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 29, 1928</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>high school</b>	9. AGE (In years last birthday) <b>29</b> IF UNDER 1 YEAR Months Days Hours Min. 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. BIRTHPLACE (City and state or country) <b>North Platte, Nebraska</b>		13a. FATHER'S NAME <b>Prof. Arthur W. Klinck, Ph.D.</b>	
13b. MOTHER'S MAIDEN NAME <b>Flora Buettner</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		17. INFORMANT Address <b>Prof. Arthur W. Klinck, 21 Seminary Terrace</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HODGKINS DISEASE OF LYMPH</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>NODES, SPLEEN, BONE, AND PLEURA</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>201x</b>		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>MAY 1957</b> to <b>Dec 19, 1957</b> and last saw him alive on <b>Dec. 19, 1957</b> Death occurred at <b>4:10 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Herbert C. Smith MD</b>		22b. ADDRESS <b>508 N. Grand</b>	22c. DATE SIGNED <b>12/20/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>Dec. 23, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Our Redeemer Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 21 '57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b> mgB

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

OL 2-7360

Dr. Herbert C. Sweet  
508 N. Grand  
3:30 PM to possibly 5 PM

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 *Delia J. Krupin*

Licensed Embalmer No. *3497*  
P. O. Address *St. Louis*

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.