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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-030639
STATE FILE NUMBER

REC AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7990

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [X] No [ ]

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 15 Lutheran Hosp — Length of stay in 1b 2 1790

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY 1

c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]

d. STREET ADDRESS (If outside, give location) 1715 Longfellow — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Anna Middle Last Kloer

4. DATE OF DEATH Month Day Year Aug 15, 1958

5. SEX Female 1

6. COLOR OR RACE White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]

8. DATE OF BIRTH Oct 9 1868

9. AGE (In years last birthday) 89 — 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) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (City and state or country) St. Louis Mo 0

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Unknown Norton

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE William Kloer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT Address Ann Groll 1715 Longfellow

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) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis — several yrs
DUE TO (c) 331 X
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 [X] NO [ ] 1

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

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 8/11/58, to 8/15/58 and last saw her alive on 8/14/58
Death occurred at 2:45 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Frede Mortensen, MD 0

22b. ADDRESS 3701 Grandel Sq

22c. DATE SIGNED 8/16/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE Aug 18, 58

23c. NAME OF CEMETERY OR CREMATORY Resurrection

23d. LOCATION (City, town, or county) (State) St. Louis Cty Mo

24. FUNERAL DIRECTOR E. J. SCHNUR — ADDRESS 3125 LAFAYETTE

25. DATE RECD. BY LOCAL REG. AUG 18 '58

26. REGISTRAR'S SIGNATURE J Earl Smith - MD
acm

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.