

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006151

STATE FILE NUMBER

FILED MAR 13 1959

Registration District No. 160 Primary Registration District No. 3030 Registrar's No. 31

300  
-57

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Festus</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Crystal City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>704 Moore St.</u>		Length of stay in lb <u>8 months</u>	d. STREET ADDRESS (If outside, give location) <u>901 Burgess Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Isabelle</u> Middle <u>Marsi</u> Last <u>Klein</u>			4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1959</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 5, 1875</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Ste. Genevieve County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Henry Rudloff</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Allgire</u>	14. NAME OF HUSBAND OR WIFE <u>August W. Klein</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Shelby Cromwell, 901 Burgess, Crystal City.</u>
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18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 years</u> <u>29</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour <u>    </u> Month, Day, Year a.m. <u>    </u> p.m. <u>    </u>	20d. INJURY OCCURRED WHILE AT WORK <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 <u>Crystal City, Mo.</u>	COUNTY <u>Mo.</u>	STATE <u>Mo.</u>
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21. I attended the deceased from <u>Dec 7-1954</u> to <u>Mar 1st 1959</u> and last saw her alive on <u>Feb 1st 1959</u> Death occurred at <u>543 1/2 W. Main</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>J. Comberford MD</u> (Degree or title)	e' 22b. ADDRESS <u>Crystal City Mo</u>	22c. DATE SIGNED <u>Mar 2-1959</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>March 4, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Crystal City, Mo.</u>
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24. FUNERAL DIRECTOR <u>Vinyard Fin'l Homes, Inc., Festus, Mo.</u>	ADDRESS <u>    </u>	25. DATE RECD. BY LOCAL REG. <u>3-4-59</u>	26. REGISTRAR'S SIGNATURE <u>Paul A. Dizon</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

