t. Health,
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-011094
STATE FILE NUMBER

MAR 17 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2224

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO — Inside Limits: Yes [✓] No [ ]

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): CITY HOSPITAL — Length of stay in 1b: 14 hrs.

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

c. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes [✓] No [ ]

d. STREET ADDRESS (If outside, give location): 3723 OLIVE — Reside on Farm: Yes [ ] No [✓]

3. NAME OF DECEASED (Type or print): First: AUGUST — Middle: MARION — Last: KLEIN

4. DATE OF DEATH: Month 3 - Day 3 - Year 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [✓] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 2-13-1903

9. AGE (In years last birthday): 56 — 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): DETECTIVE

10b. KIND OF BUSINESS OR INDUSTRY: PINKERTONS AGY.

11. BIRTHPLACE (City and state or country): ST. LOUIS, MO

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME: AUGUST KLEIN

13b. MOTHER'S MAIDEN NAME: LYDIA KREIMEIER

14. NAME OF HUSBAND OR WIFE: NONE

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.: 490-20-9844

17. INFORMANT: MRS AUGUSTA KLEIN — Address: 2819 59th

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): Labor Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 490X
INTERVAL BETWEEN ONSET AND DEATH

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 [✓] NO [ ]

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 _____ to _____ and last saw her/him alive on _____
Death occurred at 525A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] — 3

22b. ADDRESS: 1300 [illegible]

22c. DATE SIGNED: 3/3/59

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

23b. DATE: 3-6-59

23c. NAME OF CEMETERY OR ~~CREMATORY~~: LAKEWOOD PARK

23d. LOCATION (City, town, or county) (State): ST. LOUIS COUNTY MO

24. FUNERAL DIRECTOR: HOWARD MICHEL — ADDRESS: 5930 SOUTHWEST

25. DATE RECD. BY LOCAL REG.: MAR 3 '59

26. REGISTRAR'S SIGNATURE: [signature] Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 ..... Signed V. E. Morris

Signature of Student Embalmer

Licensed Embalmer No. 3360

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.