

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011097

STATE FILE NUMBER

2 2946

S. 300

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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  
MEDICAL CERTIFICATION

APR 6 1959		Registration District No. _____		Primary Registration District No. _____		Registry No. 2946		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Clinton</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Breese</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>BARNES HOSPITAL</u>			Length of stay in 1b _____		d. STREET ADDRESS <u>416 N. 6th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VICTOR</u> Middle <u>T.</u> Last <u>KLU THO</u>				4. DATE OF DEATH <u>MARCH 21, 1959</u> Month <u>MARCH</u> Day <u>21</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 29, 1894</u>		9. AGE (In years last birthday) <u>64</u>	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) <u>Conductor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (City and state or country) <u>Breese, Illinois, I</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Theodore Klutho</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Peek</u>			14. NAME OF HUSBAND OR WIFE <u>Elizabeth Klutho</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes W. W. # 2</u>		16. SOCIAL SECURITY NO. <u>705-12-0973</u>		17. INFORMANT Address <u>Elizabeth Klutho, Breese, Illinois.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS, PRIMARY SITE UNKNOWN</u>							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. } DUE TO (b) _____								
DUE TO (c) <u>199.2</u>								
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 <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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
20e. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____						
21. I attended the deceased from <u>MARCH 19, 1959</u> to <u>MARCH 21, 1959</u> and last saw <sup>her</sup> him alive on <u>MARCH 21, 1959</u> Death occurred at <u>11:10 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>H. Bradley</u> (Degree or title) <u>M. D.</u>				22b. ADDRESS <u>BARNES HOSPITAL</u>			22c. DATE SIGNED <u>3/22/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3-22-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>		23d. LOCATION (City, town, or county) <u>Breese, Illinois.</u> (State)			
24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe 4700 Washington, Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>MAR 23 '59</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>		

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 *Elmer R. Caldwell* .....

Licensed Embalmer No. *4077* .....

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.