Health, & Welfare Public Service

. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-011796
STATE FILE NUMBER

FILED MAR 30 1959 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 819

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN Pine Lawn — Inside Limits Yes X No
c. FULL NAME OF HOSPITAL OR INSTITUTION 2308 Kienlen — Length of stay in 1b 28 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Pine Lawn 4301 — Inside Limits Yes X No
d. STREET ADDRESS (If outside, give location) 2308 Kienlen — Reside on Farm Yes No X

3. NAME OF DECEASED (Type or print) First: Celia Middle: Last: Wyand
4. DATE OF DEATH Month 3 Day 25 Year 59
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐
8. DATE OF BIRTH 12-20-1870
9. AGE (In years last birthday) 88 — 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 Own Home
11. BIRTHPLACE (City and state or country) Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Martin Kleine
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Deceased
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 Mabel Koellhoffer Address 2308 Kienlen Ave.

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) Cerebrovascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 6 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Senility
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ O

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 3-15-59, to 3-25-59 and last saw her/him alive on 3-24-59
Death occurred at m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M.D.
22b. ADDRESS
22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 3-28-1959
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) St. Louis (State) Missouri

24. FUNERAL DIRECTOR Jos. W. Clark F.H. ADDRESS 1125 Hodiamont
25. DATE RECD. BY LOCAL REG. 3-26-59
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Alfred J. Bodek

Licensed Embalmer No. 2463

P. O. Address 1125 Hudson

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.