

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016065
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1214

FILED MAY 8 1959

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		c. CITY OR TOWN <u>4151 PINE LAWN</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>COUNTY HOSPITAL 19 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>3725 SALOME AVE</u>	

3. NAME OF DECEASED (Type or print) First <u>KLAUS</u> Middle <u>MEIER</u> Last <u>KLAUSMEIER</u>			4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>59</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 22, 1892</u>		9. AGE (In years last birthday) <u>66</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>RETIRED CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GLOBE DEMOCRAT</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS, MO</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>FRED KLAUSMEIER</u>		13b. MOTHER'S MAIDEN NAME <u>EMMA KASTEN</u>		
14. NAME OF HUSBAND OR WIFE <u>NONE</u>		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>unk</u>		
17. INFORMANT <u>EDWARD KLAUSMEIER</u>		Address <u>3725 SALOME</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>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>332X</u>
DUE TO (b) <u>Cerebral Arteriosclerosis</u>		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Arteriosclerotic Heart Disease

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

21. I attended the deceased from 4-11-59 to 5-1-59 and last saw ^{her}/_{him} alive on 5-1-59
Death occurred at 3:40 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Clare M. Faye M.D.</u>	22b. ADDRESS <u>601 So. Brentwood</u>	22c. DATE SIGNED <u>5/1/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-4-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS Co. MO</u>
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24. FUNERAL DIRECTOR <u>CALVIN F. FEUTZ</u>	ADDRESS <u>4828 NAT'L BRIDGE</u>	25. DATE RECD. BY LOCAL REG. <u>5-4-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</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

300
1-57

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 *Ralph C. Linder*

Licensed Embalmer No. *4225*
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.