

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023088

STATE FILE NUMBER

2 No. 5028

FILED JUN 19 1959

Registration District No. Primary Registration District No.

Registration District No. 2 No. 5028

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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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis (12)		c. CITY OR TOWN University City 30	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hosp		d. STREET ADDRESS (If outside, give location) 8000 Delmar Blvd.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
EMMA LINA KLEINSCHMIDT		May 22, 1959	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1872
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) Manchester, Missouri
13a. FATHER'S NAME John Henry Schaberg		13b. MOTHER'S MAIDEN NAME Rosina Grapp	14. NAME OF HUSBAND OR WIFE William A. Kleinschmidt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Ida E. Schaberg 8000 Delmar Blvd. (30)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>gangrene, left foot.</i> DUE TO (b) <i>Peripheral arteriosclerosis.</i> DUE TO (c) <i>4501</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>2 mos.</i> <i>7 y m.</i>
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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	COUNTY STATE
21. I attended the deceased from <i>2-5-59</i> to <i>5-22-59</i> and last saw her alive on <i>5-22-59</i> . Death occurred at <i>7:30</i> P. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R. Todd Fray Jr MD</i>		22b. ADDRESS <i>3720 Washy Ln</i>	22c. DATE SIGNED <i>5-23-59.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>5/25/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Bellefontaine Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Missouri</i>
24. FUNERAL DIRECTOR <i>Alexander & Sons, 6175 Delmar</i>		25. DATE RECD. BY LOCAL REG. <i>MAY 25 '59</i> REGISTRAR'S SIGNATURE <i>Ryan Smith, M.D.</i>	

M. G. 18.

B. Todd Forsyth,
3720 Washington,

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 *Joseph M. McCullough*

Licensed Embalmer No. *2461*

P. O. Address *6175 1/2 Elm*

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.