

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023728

STATE FILE NUMBER

FILED JUN 26 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1567

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch Mo		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN ST LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ROBT KOCH HOSP		Length of stay in lb 274 days	d. STREET ADDRESS (If outside, give location) 4224 GRACE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE - KLOECKNER			4. DATE OF DEATH Month Day Year JUNE 7 1959
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 5 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST LOUIS Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME WILLIAM KLOECKNER	
13b. MOTHER'S MAIDEN NAME MARY MENMEKES		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 497-03-9399	17. INFORMANT Address Hospital Road Robt Koch Hosp Koch Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFRACTION DUE TO (b) CORONARY THROMBOSIS DUE TO (c) 4201A PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PULMONARY TUBERCULOSIS			INTERVAL BETWEEN ONSET AND DEATH 7 DAYS
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK <input type="checkbox"/> 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 Sept 6 1958 to June 7/59 and last saw him alive on June 7/59 Death occurred at 5:06 p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Frank Cohen M.D.		22b. ADDRESS Robt Koch Hosp Koch Mo	22c. DATE SIGNED 6-8-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-11-59	23c. NAME OF CEMETERY OR CREMATORY Resurrection	23d. LOCATION (City, town, or county) (State) St. Louis Mo
24. FUNERAL DIRECTOR ADDRESS Edw, Fendler Mortuary, 5611 So. Grand		25. DATE RECD. BY LOCAL REG. 6-9-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *T. O. Humphrey*

Licensed Embalmer No. *#4772*
P. O. Address *Sullivan 711*

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.