

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS AUG 11 1959**

**59-026846**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 7046** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>	Length of stay in 1b <b>19 Yrs.</b>	c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home Of The Friendless</b>		d. STREET ADDRESS <b>4431 So. Broadway</b>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Ida May Klein</b>	First Middle Last	4. DATE OF DEATH <b>July 29 1959</b>	Month Day Year
---	-------------------	---	----------------

5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/6/1872</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.
--------------------	------------------------------	---	-------------------------------------	-------------------------------------	--------------------------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Hosewife</b>	11. BIRTHPLACE (City and state or country) <b>Minnesota</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
---	--	--	--

13a. FATHER'S NAME <b>Andrew Reibera</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Tain</b>	14. NAME OF HUSBAND OR WIFE <b>Edward Klein</b>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT Address <b>Home Of The Friendless 4431 So. Bdw</b>
---	--------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Mesenteric thrombosis</b>		<b>2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis, generalized</b>	<b>several yrs.</b>
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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. Month, Day, Year <b>7:00 P.M. April 15, 1959</b>	20d. INJURY OCCURRED WHILE AT WORK <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 <b>April 15, 1959</b> to <b>July 29, 1959</b> and last saw her <b>alive</b> on <b>July 29, 1959</b> Death occurred at <b>5:50 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <b>Benjamin H. Charles M.D.</b>	22b. ADDRESS <b>3720 Washington Blvd. St. Louis</b>	22c. DATE SIGNED <b>7/30/59</b>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>July 31, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
---	-----------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <b>Hoffmeister Colonial Mortuary 6464 Chippewa St. St. Louis, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 30 1959</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>
---	--	--

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John Shenn

Licensed Embalmer No. 4194

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.