RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS SEP 11 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 8007

59-030312 STATE FILE NUMBER

DED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST LOUIS CITY # 1
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3455 OREGON
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Fred; Middle: H.; Last: Cluss

4. DATE OF DEATH: Month: August; Day: 25; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 11-13-1871

9. AGE (last birthday): 87

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Sheet Metal Worker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): Wisconsin

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: John Cluss

13b. MOTHER'S MAIDEN NAME: Anna Thoman

14. NAME OF ~~HUSBAND~~ OR WIFE: Christina Cluss

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.: 488-18-6409

17. INFORMANT: Christina Cluss Address: 3455 Oregon

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) Thrombosis of Basilar Artery — INTERVAL BETWEEN ONSET AND DEATH: 1 Week

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Cerebral Arteriosclerosis — 10 yrs

DUE TO (c) 332x — –

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

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 August 22, 1959, to August 25, 1959 and last saw her/him alive on August 25, 1959

Death occurred at 7:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John W. Steinich (Degree or title) M.D.

22b. ADDRESS: 1515 Lafayette Ave.

22c. DATE SIGNED: 8-25-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: Aug 29, 1959

23c. NAME OF CEMETERY OR CREMATORY: St. Paul Churchyard

23d. LOCATION (City, town, or county): St. Louis Co. (State): Mo.

24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois

25. DATE RECD. BY LOCAL REG.: AUG 28 '59

26. REGISTRAR'S SIGNATURE: Hoard Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF

DOCUMENT

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2916

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