

# FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

**FILED VS AUG 31 1959**

**59-030546**

**2 7600**

STATE FILE NUMBER

DED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence, before admission) a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>  c. CITY OR TOWN <b>Lemay</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS <b>244 Military Rd.</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
---	--	--	--

<b>3. NAME OF DECEASED</b> (Type or print) First <b>Erwin</b> Middle <b>L</b> Last <b>Kleinecke, Sr.</b>	<b>4. DATE OF DEATH</b> Month <b>Aug.</b> Day <b>15</b> Year <b>1959</b>
--	--

<b>5. SEX</b> male	<b>6. COLOR OR RACE</b> white	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> Mar 4, 1891	<b>9. AGE (last birthday)</b> 68	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
-----------------------	----------------------------------	---	--	-------------------------------------	---	---

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Letter Carrier</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>St Louis Mo.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
--	---	--	--

<b>13a. FATHER'S NAME</b> <b>Robert Kleinecke</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Kate Spies</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Irene Kleinecke</b>
--	---	--

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	<b>16. SOCIAL SECURITY NO.</b> _____	<b>17. INFORMANT</b> Address <b>Irene Kleinecke 244 Military Rd.</b>
---	---	---

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ } DUE TO (c) <b>163X</b>	INTERVAL BETWEEN ONSET AND DEATH <b>8mo</b>
--	--

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 type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____
--	---	---	--	---

<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY _____ STATE _____
--	--	---	--

<b>21. I attended the deceased from</b> <b>5/18/59</b> to <b>8/15/59</b> and last saw <sup>her</sup> <del>him</del> <sup>alive</sup> on <b>8/14/59</b> Death occurred at <b>4:15</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
---

<b>22a. SIGNATURE</b> (Degree or title) <b>Edward W. Czuchra M.D.</b>	<b>22b. ADDRESS</b> <b>3701 Grandel Sq</b>	<b>22c. DATE SIGNED</b> <b>8/15/59</b> (State)
--	---	---

<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>Aug 18, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>New St Marcus Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) <b>St Louis Mo.</b>
---	---	--	--

<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>John L Ziegenhein &amp; Sons 7027 Gravois</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>AUG 17 '59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Leon 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 C. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Glava

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.