

# JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042093

FILED VS DEC 11 1959

210738

STATE FILE NUMBER

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 MO</b> Length of stay in lb _____		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY _____  c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <b>1827<sup>1/2</sup> S. COMPTON</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>CARL</b> Middle <b>KLOTZ</b> Last _____			<b>4. DATE OF DEATH</b> Month <b>Nov.</b> Day <b>17<sup>th</sup></b> Year <b>1959</b>				
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11/6/1896</b>	<b>9. AGE (last birthday)</b> <b>63</b>	<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>TILE SETTER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and state or country) <b>GERMANY</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	

<b>13a. FATHER'S NAME</b> <b>FREDERICK KLOTZ</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>MINNIE SCHIMANKA</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>EMMA KLOTZ (DECEASED)</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>488-07-9196</b>
<b>17. INFORMANT</b> Address <b>TERESA MOORE 1427 OBEAR</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>Coronary Occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH   
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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		
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<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 _____

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at **1049A** \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <i>Thomas H. Kates</i>	<b>22b. ADDRESS</b> <b>1302 Oak</b>	<b>22c. DATE SIGNED</b> <b>11/21/59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>REMOVAL</b>	<b>23b. DATE</b> <b>Nov. 21 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>HIRAM CEM.</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>ST. LOUIS MO</b>

<b>24. GENERAL DIRECTOR</b> ADDRESS <b>Thomas H. Kates 2906 Prairie</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>NOV 21 1959</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Earl Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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STATEMENT BY LICENSED EMBALMER

MAR 21 1960

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me  
or by Not Embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Prado

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.