

# FEDERAL BUREAU OF INVESTIGATION

## FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 18 1960

STATE FILE NUMBER  
**212092 - 59-046996**

INDEXED

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

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>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b _____	c. CITY OR TOWN <b>Ladue</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>Lutheran Con. Home</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>#30 Mid Park Lane</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARETHA</b> Middle <b>A.</b> Last <b>KLEIN</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-13-1875</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Milliner (Self Employed)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Jacob Klein</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Herold</b>		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) <b>No</b>		16. SOCIAL SECURITY NO. <b>492-05-9740A</b>	17. INFORMANT <b>Eleanore E. Klein #30 Mid Park La.</b> Address _____			
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>Cerebro-Vas. Disease.</b>					<b>7 mos.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>A. S. H. D.</b>					<b>3 1/2 yrs.</b>	
DUE TO (c) <b>Heav. Art. Pellets - 420.0</b>					<b>---</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 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. _____ p.m. Month, Day, Year _____		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>July 4 '57</b> to <b>Dec. 28 '57</b> and last saw her/him alive on <b>Dec. 20 '57</b> Death occurred at <b>3:30 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>P. H. Koch M.D.</b> (Degree or title)			22b. ADDRESS <b>1504 S. Grand.</b>		22c. DATE SIGNED <b>12.29.59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Dec. 30, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>		
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>DEC 29 1959</b>	26. REGISTRAR'S SIGNATURE <b>Earl 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 R. W. Stovssand

Licensed Embalmer No. 4007

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.