

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 26 1960 318 Primary Registration District No. 1003 Registrar's No. 9965 -60-039903 STATE FILE NUMBER

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|--|--|---|--|--|--|--|---|--|------|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 2-wks. | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 409 St. George St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Theodore Middle Kling Last | | | | 4. DATE OF DEATH Month Oct. Day 14, Year 1960 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 4/24/91 | 9. AGE (last birthday) 69 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY Grocer | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME Leonard Kling | | | 13b. MOTHER'S MAIDEN NAME Mary Leicht | | | 14. NAME OF HUSBAND OR WIFE Emma | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W. #1 | | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Address John Kling - 1710 So. 8th St. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia - left lung BRONCHO PNEUMONIA - LEFT LUNG | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 wks | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | DUE TO (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 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 Month, Day, Year a.m. p.m. | | | 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 9/27/60 to 10/14/60 and last saw ^{her} him alive on 10/14/60 Death occurred at 7:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) George A. Deane MD | | | | 22b. ADDRESS 6500 Chippewa | | | | 22c. DATE SIGNED 10/14/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE Oct. 17, 1960 | 23c. NAME OF CEMETERY OR CREMATORY National Cemetery | | | 23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo. | | | |
| 24. FUNERAL DIRECTOR ADDRESS WACKER-HELDERLE-3634 Gravois Ave. | | | | 25. DATE RECD. BY LOCAL REG. OCT 14 1960 | | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. | | | |

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 Robert J. Crispin

Licensed Embalmer No. 349

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.