RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

No. 9 1961 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12183 STATE FILE NUMBER 60-042645

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis, Length of stay in 1b	c. CITY OR TOWN St.Louis, Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Baptist Hosp. Inside Limits Yes ☐ No ☐	d. STREET ADDRESS (If outside, give location) 4216a Olive Str. Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
CARRIE	ROSE	KLINGENBERG	Dec.	18,	1960

5. SEX	6. COLOR OR RACE	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
Female	White		5-18-1882	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
Housewife	Home	Milton, Vermont	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Emery Mason	Clara LaFlash	William C.Klingenberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	498-03-7080	William C.Klingenberg	4216a Olive

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) Myocardial infarction with — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Cardiovascular failure — 3-4 Days

DUE TO (c) 420.1F

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

O.K. [illegible] Paul Smith 12/19/60 Dec 12 1960

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Fracture Rt. humerus

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.) Fall down at home

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year Dec 12/60

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.) home

20f. CITY, TOWN, OR LOCATION St. Louis COUNTY Mo STATE

21. I attended the deceased from 12-16-60, to 12-18-60 and last saw her/him alive on 12-18-60

Death occurred at 1:21 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [illegible] MD (Degree or title) — 22b. ADDRESS 453 N. Taylor Ave. — 22c. DATE SIGNED 12-19-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation — 23b. DATE Dec.20,1960 — 23c. NAME OF CEMETERY OR CREMATORY Mo. Crematory — 23d. LOCATION (City, town, or county) St.Louis, (State) Mo.

24. FUNERAL DIRECTOR Kriegshauser — ADDRESS 4228 S.Kingshighway — 25. DATE RECD. BY LOCAL REG. DEC 19 1960 — 26. REGISTRAR'S SIGNATURE Paul Smith. M.D.

DOCUMENT

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_____ Signed William B White

Signature of Student Embalmer

Licensed Embalmer No. 4291

P. O. Address 228 [illegible]

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