SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-011114
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3212

FILED APR 14 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: City Hospital
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5505 Finkman Ave.
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First WILLIAM Middle F. Last KLASING
4. DATE OF DEATH: Month Apr. Day 3 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 10-25-1904
9. AGE (last birthday): 56
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shop Foreman-Southern Comfort Co.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Germany
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Unknown Klasing
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Late Edith Klasing
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
17. INFORMANT: Jo Ann Langsdorf Address: 149 E. Bertrand Dr.(29)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning, suffered in garage in
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) rear of home on or about April 3, 1961.
DUE TO (c) Suicide 973.1
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ 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.) See above
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 4-3-61
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, Mo COUNTY STATE
21. I attended the deceased from ____ to ____ and last saw her/him alive on ____
Death occurred at 11:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Patrick E Taylor (Degree or title) Coroner
22b. ADDRESS 1300 Clark
22c. DATE SIGNED 4-5-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal(Mtr)
23b. DATE Apr. 6, 1961
23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery
23d. LOCATION (City, town, or county) (State) Collinsville, Ill.
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway Blvd.
25. DATE RECD. BY LOCAL REG. APR 5 1961
26. REGISTRAR'S SIGNATURE Earl Smith M.D.

MEDICAL CERTIFICATION

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed R. W. Storsand

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 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.