

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3616 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 2 1962

VS 300 Rev. 4/59

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DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY - - -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY - - -	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>St. Louis, Missouri</u>		Length of stay in lb <u>lifetime</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5301 Page</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>(n.m.i.)</u> Last <u>Klinge</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE (last birthday) <u>93</u> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR: Hours Min.
11. BIRTHPLACE (City and state or country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY <u>Naturalized</u>	
13a. FATHER'S NAME <u>William Kirch</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Rick</u>	
14. NAME OF HUSBAND OR WIFE <u>William F. Klinge</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT Address <u>Oscar K. Merkle 5600 Itaska</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Fracture rt hip (femur)</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>7-10 days</u> <u>10-14 days</u> <u>18 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Age 904.7.45</u>			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.) <u>Fell in Nursing Home</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>March 16 62</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <u>06 St Ann Nursing Home</u>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>5301 Page</u>	COUNTY STATE <u>St. Louis Mo</u>
21. I attended the deceased from <u>3/17/62</u> to <u>4/3/62</u> and last saw <sup>her</sup> him alive on <u>4/3/62</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James J. Golden, MD</u>		22b. ADDRESS <u>4919 Forest Park</u>	22c. DATE SIGNED <u>4/5/62</u>
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-6-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>
24. FUNERAL DIRECTOR <u>HOFFMEISTER COLONIAL MORTUARY</u>		25. DATE RECD. BY LOCAL REG. <u>SAM APR 5 1962</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>



Dr. Gilden  
4919 Forest Park Blvd.

after 1:30

**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 John L. Denny

Licensed Embalmer No. 4194

P. O. Address St. Louis, MO.

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.