

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008913

FILED FEB 19 1963

1003

1147

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros.		d. STREET ADDRESS (If outside, give location) 4314 So 37th St.	
3. NAME OF DECEASED (Type or print) First Middle Last A. LOUISE KLEIN		4. DATE OF DEATH Month Day Year 2-1-1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-22-1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country). St. Louis Mo.
13a. FATHER'S NAME Henry Leibig		13b. MOTHER'S MAIDEN NAME Augusta Leibig	13c. NAME OF HUSBAND OR WIFE Deceased
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give dates) NO NONE		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of left hip. Generalized arteriosclerosis. Suffered in fall in home on January 23, 1963.		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 SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. 2 1-23-63		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See above	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis, Mo	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 10:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Walter L. Taylor, Coroner		22b. ADDRESS 1300 Clark Ave.	
22c. DATE SIGNED 2-4-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-4-1963	
23c. NAME OF CEMETERY OR CREMATORY St. Peters Cem.		23d. LOCATION (City, town, or county) (State) St. Louis Co. MO.	
24. FUNERAL DIRECTOR ADDRESS WINGBERMOEHL 3819 SO Grand Blvd		25. DATE RECD. BY LOCAL REG. FEB 4 1963	
26. REGISTRAR'S SIGNATURE Paul Smith, M.D.			

VS 300
Rev. 4/59

1

2 **2159**

3

4 **1**

5 **3**

6

7 **0**

8 **2**

9

10

11 **600**

12 **50-3**

13

50

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

SHOULD READ

ITEM NO.

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

George J. Kingbermehl

Licensed Embalmer No. 4611

P. O. Address Adams 18 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.