

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021819

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5726 STATE FILE NUMBER

FILED JUN 13 1963

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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STATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>		b. CITY (if outside corporate limits, give TOWNSHIP only) <i>St. Louis</i>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY		c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Park Lane Hosp.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <i>3407A Keokuk</i>		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>G.</i> Last <i>Klos</i>						4. DATE OF DEATH Month <i>5</i> Day <i>29</i> Year <i>63</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>1/4/1895</i>		9. AGE (last birthday) <i>68</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At home</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>			
13a. FATHER'S NAME <i>John Kalish</i>				13b. MOTHER'S MAIDEN NAME <i>A Not Known</i>				14. NAME OF HUSBAND OR WIFE <i>Leo Klos</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (if yes, give war or dates) <i>No</i>						NO. <i>95</i>		17. INFORMANT Address <i>Leo Klos 3407A Keokuk</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio-Sclerotic Heart Disease</i> DUE TO (b) <i>Fracture, Left Hip</i> DUE TO (c) <i>904.0-21</i> Condition if any, which gave rise to above cause (a), stating the date lying down last.										INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i> <i>3 wks.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>6-3-63</i>								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.) <i>Fell at home</i>							
20c. TIME OF INJURY Hour <i>?</i> a.m. <i>?</i> p.m. <i>?</i>		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.) <i>16 home</i>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>3407a Keokuk St. Louis, Mo.</i>									
21. I attended the deceased from <i>1st May 1963</i> to <i>29 May 63</i> and last saw her alive on <i>28 May 63</i> . Death occurred at <i>7:20 AM</i> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>John Wilson M.D.</i>						22b. ADDRESS <i>Maplewood Mo</i>		22c. DATE SIGNED <i>5/29/63</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/31/1963</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>					
24. FUNERAL DIRECTOR ADDRESS <i>Wingbermuehle Funeral Home So. Grand</i>						25. DATE RECD. BY LOCAL REG. <i>MAY 31 1963</i>		26. REGISTRAR'S SIGNATURE <i>Ronald Smith, M.D.</i>			

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. John Briscoe

200 21 102 02117

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 *Geo J. Schumacher*

Licensed Embalmer No. 4611
P. O. Address St. Louis 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.