

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-028286

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 209

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 8 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>JEFFERSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. CHARLES</u>		Length of stay in 1b <u>13 DAYS</u>	c. CITY OR TOWN <u>DE SOTO</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPHS Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>ROUTE #1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>ALBERT</u> Last <u>KLEINSCHMIDT</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>28</u> Year <u>1962</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/10/25</u>
9. AGE (last birthday) <u>87</u>		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) <u>RET. FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>DE SOTO, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>LOUIS A. KLEINSCHMIDT</u>	
13b. MOTHER'S MAIDEN NAME <u>MARIA MOEHLMAN</u>		14. NAME OF HUSBAND OR WIFE <u>MARGARET KLEINSCHMIDT</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>NO.</u>	17. INFORMANT <u>MELVIN A. KLEINSCHMIDT</u> Address <u>GRANITE CITY ILLINOIS</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>arteriosclerotic heart</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>disease, i.e. decompensation.</u>			
DUE TO (c) _____			
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. <input type="checkbox"/> Yes <input 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	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.) <u>June '62</u>	20f. CITY, TOWN, OR LOCATION <u>Present</u>	20g. COUNTY <u>Mo.</u>	
21. I attended the deceased from <u>7/28/62</u> to <u>7/27/62</u> and last saw him alive on <u>7/27/62</u> Death occurred at <u>1:40 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>7/28/62</u>	
22a. SIGNATURE <u>Galpey, m</u> (Degree or title)		22b. ADDRESS <u>304 So. 2nd St. Charles, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>JULY 28 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>	23d. LOCATION (City, town, or county) <u>DE SOTO Mo.</u>
24. FUNERAL DIRECTOR <u>DIETRICH F HOME</u> ADDRESS <u>DE SOTO Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-28-62</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>	

USE BLACK INK OR TYPEWRITER RIBBON

AUG 21 1962

AUG 9 1962

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 Donnell P. [Signature]

Licensed Embalmer No. 4104

P. O. Address Deputy No.

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.