SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

FILED OCT 13 1961

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8970

-61-034558
STATE FILE NUMBER

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

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: 1226a Shawmut Pl.
Inside Limits: Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis
Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 1226a Shawmut Pl.
Reside on Farm: Yes ☐ No X

3. NAME OF DECEASED (Type or print): First James Middle P Last Kloeppel

4. DATE OF DEATH: Month 9 Day 28 Year 61

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed X Divorced ☐
8. DATE OF BIRTH: 1-1-1883
9. AGE (last birthday): 78
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): Lumberman
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Linn Missouri
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: William Kloeppel
13b. MOTHER'S MAIDEN NAME: Elizabeth Flangan
14. NAME OF HUSBAND OR WIFE: Iva Kloeppel Dec.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNK.
17. INFORMANT Address: Mildred Kloeppel 1226a Shawmut Pl.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Thrombosis	3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Generalized Arteriosclerosis	15 yrs
DUE TO (c)	Diabetes Mellitus	15 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): None 260 x

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO X
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
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.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Sept 8, 1961, to Sept 28 1961 and last saw him alive on Sept 17, 1961
Death occurred at 7:30a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Kenneth R. Wood MD
22b. ADDRESS: 3442 Geraldine St Louis 16 Mo
22c. DATE SIGNED: 9-28-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10-2-61
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis Co. Missouri

24. FUNERAL DIRECTOR ADDRESS: J.W.Clark F.H.1125 Hodiamont Ave.
25. DATE RECD. BY LOCAL REG.: SEP 28 1961
26. REGISTRAR'S SIGNATURE: Hoad Smith, M.D.

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 4504

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.

Dr. B Wood
3442 Gerldn Ave.