Health,
& Welfare
Public
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S. 300
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-019865
STATE FILE NUMBER

MAY 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5292

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY -	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis	Inside Limits Yes ☒ No ☐	c. CITY OR TOWN St.Louis	Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5219a Ashland	Length of stay in 1b 15 Yrs. 2069	d. STREET ADDRESS (If outside, give location) 5219a Ashland	Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First IVA	Middle M.	Last KLOEPPEL	4. DATE OF DEATH Month May Day 17 Year 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH Apr.28,1883	9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Chamois, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Phillip Saner	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE James Kloeppel		
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. None	17. INFORMANT Mildred Kloeppel, Address 5219a Ashland		

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)	Cor Myocardia	1948
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Hyp Nephritis	1950
DUE TO (c)	Arteriosclerosis Diabetes mellitus	1935 1940

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 Jan 3 1938 to May 17-58 and last saw her/him alive on 5-16-58
Death occurred at 3:05 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Roy Johnson MD (Degree or title)	22b. ADDRESS Ferguson MO	22c. DATE SIGNED 5/19/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 20,1958	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION (City, town, or County) St. Louis County, Mo.	(State)
24. FUNERAL DIRECTOR TANNER FUNERAL HOME,	ADDRESS 6107 Natl. Br.	25. DATE RECD. BY LOCAL REG. MAY 20 58	26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. M.D.	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 Stanley H. Sisson

Licensed Embalmer No. 4193

P. O. Address [illegible]

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.