

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21776

State File No. \_\_\_\_\_

FILED AUG 3 1945  
318

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003Registrar's No. 6356

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: City Hospital  
Max C. Sterkloff Memorial  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 118 days  
(Specify whether  
 In this community 0  
years, months or days)

3. (a) PRINT FULL NAME GEORGE CLAUSSEN

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced 3 divorced

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 27th 1868  
(Month) (Day) (Year)8. AGE: Years 76 Months 11 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Germany  
(City, town, or county) (State or foreign country)10. Usual occupation none

11. Industry or business \_\_\_\_\_

12. Name Charles Claussen13. Birthplace Germany  
(City, town, or county) (State or foreign country)14. Maiden name Wilhemina Lubbei15. Birthplace Germany  
(City, town, or county) (State or foreign country)16. (a) Informant Arthur J. Dippel(b) Address 5203 Hampton Blvd.17. (a) Burial (b) Date thereof 7/24/45  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation New St. Marcus18. (a) Signature of funeral director [Signature](b) Address 2904 [Address]19. (a) July 23 1945 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 4022 Laclede  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country Germany

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22  
year 1945 hour 9:38 minute P M.21. I hereby certify that I attended the deceased from March 27 1945 to July 22, 1945 19\_\_\_\_;  
that I last saw him alive on July 22, 1945 19\_\_\_\_;  
and that death occurred on the date and hour stated above.Immediate cause of death Cocciemia of lungs  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions H7  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline the cause to which death should be charged statistically.

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of work) (a) Means of injury \_\_\_\_\_23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette Avenue Date signed 7/23/45

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Vergie L. Berryman*

Licensed Embalmer No.

*4018*

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 this body is not embalmed, fact should be so stated above.**