

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

40146

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis Mo* (No.....)

Registration District No..... *791*
Primary Registration District No..... *1003*

File No.....
Registered No. *12174*
St..... Ward)

2. FULL NAME

William G. Klein

(a) Residence. No. *4918 Wadaba St.* Ward. *6*
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Elizabeth Klein*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 17 - 1863*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
63 9 5

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Commissioner*
(b) General nature of industry, business, or establishment in which employed (or employer) *Merchant*
(c) Name of employer *Self*

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis Missouri*

10. NAME OF FATHER *Louis Klein*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

12. MAIDEN NAME OF MOTHER *Wilhelmina Langford*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

14. INFORMANT (Address) *Elizabeth Klein 4918 Wadaba ave*

15. FILED *DEC 24 1926* Max C. Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 22 1926*

17. I HEREBY CERTIFY, That I attended deceased from *Dec 14* to *Dec 22*, 1926 that I last saw h. *alive* on *Dec 22*, 1926 and that death occurred, on the date stated above, at *6:30* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis Chronic
93C
71B (duration) yrs. *6* mos. *1* da.

CONTRIBUTORY (SECONDARY) *Secondary Anemia* (duration) yrs. *2* mos. *1* da.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF BIRTH

B DID AN OPERATION PRECEDE DEATH? DATE OF WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *Wm. B. Baber* M. D. (Address) *6424 Barton*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL (DATE OF BURIAL) *New Parkers Dec 24 1926*

20. UNDERTAKER *Bensick & Nichols* ADDRESS *1138 N. 6th St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

