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

Do not use this space.

2616

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis Mo (No. City Hosp ..... St. ..... Ward)

File No. .....

Registered No. 176

2. FULL NAME Fred Klang

(a) Residence. No. 6722 Minnesota St., 1 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 27 1913

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	13	10	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Day

(b) General nature of industry, business, or establishment in which employed (or employer) 210 M

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Fred Klang

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Maggie Skyhill

12. MAIDEN NAME OF MOTHER Maggie Campbell

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

14. INFORMANT Maggie Klang (Address) 6722 Minnesota Av

15. FILED 6 1927 19 May C Stark Coff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-5-27 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 6 45 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Anaemia Partial Traumatic Amputation Right Leg

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Run over by Auto in City Accident

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1880

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Wm Dever, M.D.

1/7, 1927 (Address) Dep Coroner

*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
Mt Hope	Jan 7/26

20. UNDERTAKER	ADDRESS
Fendler Und Co	7819 Mich Av

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.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH

County..... Registration District No. 791 File No.....

Township..... Primary Registration District No. 1003 Registered No. 176

City St. Louis Mo. (No..... St. ..... Ward)

2. FULL NAME Fred Klang

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT.....
(Address)

15. FILED....., 19..... Mau C Starcoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 5 1927

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THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos. .....ds.

CONTRIBUTORY (SECONDARY).....
.....(duration).....yrs. .....mos. .....ds.

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IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D

, 19 (Address)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 1-7-1927

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

S-2616