

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

Do not use this space.

31432

1. PLACE OF DEATH

County St. Louis
Township Richman St.
City St. Louis (No. Dr. Mary Hop)

Registration District No. 790
Primary Registration District No. 6033

File No. 279
Registered No. 279
St. _____ Ward _____

2. FULL NAME

Unnamed - Kline
(a) Residence, No. 6233 Elizabeth Ave. St. _____
(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 Male **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (*write the word*)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-12-27

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day,** 1 **hr.** or 1 **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) St. Louis, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Oscar B. Kline

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

12. MAIDEN NAME OF MOTHER Julia Taylor

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

14. INFORMANT Frank Foster
(Address) 6016 Columbia

15. FILED 10/15/27 J. B. Sudduth REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 12th 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 - 5:45 a.m., 1927, to Oct 12 - 5:45 a.m., 1927, that I last saw him alive on Oct 12, 1927, and that death occurred, on the date stated above, at about 5:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia fatal -
some seven weeks before falling
157 B
159 (duration) yrs. mos. ds.

CONTRIBUTORY Spina-bifida
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

18 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

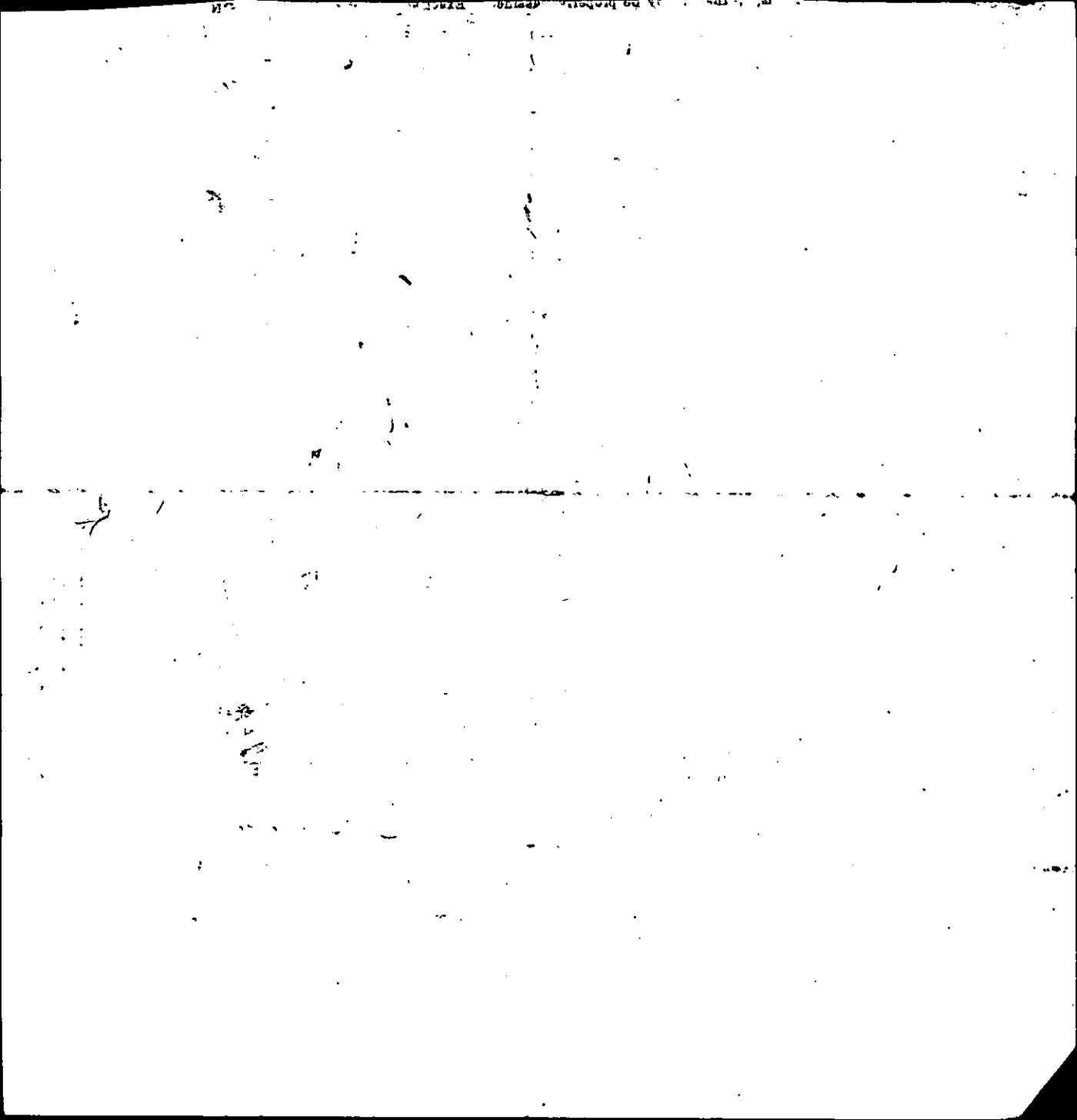
(Signed) R. B. Brent Murphy, M. D.

Oct 14 - 1927 (Address) 6120 Victoria Ave

*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 Valhalla **DATE OF BURIAL** 10/15 1927

20. UNDERTAKER Alexander & Sons **ADDRESS** 6175 Delmar



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 790 File No. _____
Township _____ Primary Registration District No. 6033 Registered No. 274
City Richmond Heights St. _____ Ward _____

2. FULL NAME

Kline (unborn infant)
(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) ss-

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 12 - 19 27

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

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 _____ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 12 - 1927

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

Premature Birth

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

CONTRIBUTORY (SECONDARY) Spinal fluid

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

18. WHERE WAS DISEASE CONTRIBUTED

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)

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)

*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.

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

15. FILED 12/8/27 J. B. Sweet REGISTRAR

20. UNDERTAKER

ADDRESS

SUPPLEMENTARY

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

Exact statement of OCCUPATION is very important.

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