

FC 28 1928

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

Do not use this space.

37495

1. PLACE OF DEATH
 County Marion Registration District No. 502
 Township _____ Primary Registration District No. 4305
 City Marceline (No. _____) St. _____ Ward _____
 File No. _____
 Registered No. 40

2. FULL NAME Joseph Klein
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 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) don't know

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
about 66 | - | - | - | or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (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) Austria Hungary

PARENTS
 10. NAME OF FATHER Frank Klein
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Vienna Austria Hungary
 12. MAIDEN NAME OF MOTHER Don't know
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) _____

14. INFORMANT Wm Stein
 (Address) Marceline Mo

15. FILED 11/30 1928 St. Paulman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 27 1928

17. I HEREBY CERTIFY That I attended deceased from Nov 27 1928 to Nov 27 1928 that I last saw him alive on Nov 27 1928 and that death occurred, on the date stated above, at 3:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Emphysema or Heart Failure
Arterio Sclerosis

(duration) Sick when died
5 yrs

CONTRIBUTORY (SECONDARY) WA
 (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Dr. S. C. ... M. D.
 , 19 (Address) Marceline Mo.

*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 Stein Cemetery DATE OF BURIAL Nov 28 1928

20. UNDERTAKER Jas M Fay Klein ADDRESS Marceline Mo

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.

