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

Do not use this space.

13120

1. PLACE OF DEATH

County ..... Registration District No. City Surviving 31

Township ..... Primary Registration District No. ..... File No. .....

City St Louis (No. 5800 Arsenal St. 3078 Ward)

2. FULL NAME Jacob Klebelect

(a) Residence No. 5800 Arsenal St., 13 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U.S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Don't Know

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't Know 1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
About	80	Unknown		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ~~Not~~ Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

237

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

16

PARENTS

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't Know
(STATE OR COUNTRY)

31

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't Know
(STATE OR COUNTRY)

31

14. INFORMANT Mrs Marie Effinger
(Address) 5800 Arsenal

15. FILED ....., 19.. Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/21/ 1929

17. I HEREBY CERTIFY, That I attended deceased from 3/1/29, 19.., to 3/21, 1929, that I last saw him alive on 3/20, 1929, and that death occurred, on the date stated above, at 6:15 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
.936
.97
(duration) ..... yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) B. Kiehbiel, M. D
3/21, 1929 (Address) 5600 Arsenal.

*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
Calvary Cemetery	Mar 26 1929
20. UNDERTAKER J. H. Gebken L & U. Co	ADDRESS 2842 Meramec

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.