SEP 26 1930

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

Do not use this space.

27424

1. PLACE OF DEATH
County: Nodaway
Township: Washington
City: Arlon (No. ..... St. ..... Ward)
Registration District No. 617
Primary Registration District No. 4367
File No. ..... Registered No. 11

2. FULL NAME: Ralph Kline

(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. 1 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 15 1930

7. AGE — YEARS | MONTHS | DAYS 1 | If LESS than 1 day, 24 hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): Arlon, Mo
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: William Grover Kline
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Andrew Co. Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Lyda Elmor
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Lee Co. Iowa
(STATE OR COUNTRY)

14. INFORMANT: William Grover Kline
(Address): Arlon Mo

15. FILED Sept 8 1930 Chas. D. Humbard M.D. REGISTRAR
Sept 8 1930 C. P. Fryer M.E.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug. 15 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1930, to Aug 15 1930, that I last saw him alive on Aug 15 1930, and that death occurred, on the date stated above, at 1:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature Birth
1.5
Hrs (duration) Stay Four yrs. ..... mos. ..... da.

CONTRIBUTORY (SECONDARY): ✓
..... (duration) ..... yrs. ..... mos. ..... da.

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) D. A. Pollard, M. D
8/16, 1930 (Address) Bonard 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: Fillmore Cemetery
DATE OF BURIAL: 8/16 1930

20. UNDERTAKER: C W Cole
ADDRESS: Fillmore 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.