

NOV 28 1930

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

Do not use this space.

34068

1. PLACE OF DEATH

County St. Louis
Township Carondelet
City Jefferson Barracks, Mo.

Registration District No. 1123
Primary Registration District No. 6248B
U.S. Veterans Hospital

File No. _____
Registered No. 346
St. _____ Ward _____

2. FULL NAME John Klingbeil

(a) Residence. No. 4049 N. Broadway, St. Louis, Mo. 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

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) Nov. 8, 1895

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
34 34 11 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Auto Trimmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

PARENTS

10. NAME OF FATHER Unavailable
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unavailable
(STATE OR COUNTRY) Unavailable
12. MAIDEN NAME OF MOTHER Unavailable
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unavailable
(STATE OR COUNTRY) Unavailable

14. INFORMANT C. E. SMITH, M.D., Clinical Director
(Address) USVet. Hosp. Jefferson Brks., Mo.

15. FILED Oct 20, 1930 L. C. Obrady REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 19, 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1930 to October 19, 1930
that I last saw h. im. alive on October 19, 1930 and that death occurred, on the date stated above, at 12:55 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pnaumonia

108
10/10 (duration) Un yrs kn mos OWN da
CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? Unknown

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Phys. exam, x-ray, clinical symptoms
(Signed) C. GIBSON, M.D., Medical Director in Charge, USVet. Hosp. Jefferson Brks., 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 Colony DATE OF BURIAL Oct 22 1930

20. UNDERTAKER Math Herman & Son ADDRESS 2161 Bour

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.

