DEC 22 1930

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

Do not use this space.

36947

1. PLACE OF DEATH

County: Osage — Registration District No.: 641 — File No.: 1V

Township: Jackson — Primary Registration District No.: 5850 — Registered No.:

City: (No. ..... St. ..... Ward)

2. FULL NAME: Henry Philip Kleffner

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

Length of residence in city or town where death occurred yrs. 1 mos. 15 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): Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct. 1 - 1930

7. AGE: Years | Months: 1 | Days: 15 | If LESS than 1 day, ... 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) (STATE OR COUNTRY): Mo.

PARENTS

10. NAME OF FATHER: Philip Kleffner
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Meta
12. MAIDEN NAME OF MOTHER: Emma Massmann
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Meta

14. INFORMANT: Philip Kleffner
(Address): Meta Mo

15. FILED Nov 15 1930 Robert Prater, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1930, to Nov. 15, 1930 that I last saw him alive on Nov. 14, 1930 and that death occurred, on the date stated above, at 6 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY)

(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) S. Barton, M. D.

11/15, 1930 (Address) Meta

*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: St Cecelia Cemetery — DATE OF BURIAL: 19

20. UNDERTAKER: H. H. Stroop — ADDRESS: Meta

N. B.—Every ... CAUSE OF DEATH in plain terms, so that it may be properly ... Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Osage — Registration District No. 641 — File No.

Township Jackson — Primary Registration District No. 5850 — Registered No. 12

City (No. St. Ward)

2. FULL NAME Henry Philip Klefner

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....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)
(STATE OR COUNTRY)

PARENTS
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)

14. INFORMANT
(Address)

15. FILED Nov 15, 1930 Robert Prater
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho Pneumonia
Did not follow
Measles or Whooping Cough
(duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
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)

*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
	Nov 16 1930
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.— ...ry item of information should be carefully ...pped. ... should be stated EXACTLY. PHYSICIANS should ... CAUSE ... properly classified. ... very ...

REGISTRARS ... OR CERTIFICATES UNTIL THE ARE COMPLETE AS PRESCRIBED BY LAW

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