

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

Do not use this space.

8328

1. PLACE OF DEATH

County Webster
Township C Dallas
City (No.)

Registration District No. 898
Primary Registration District No. 6203

File No.
Registered No. 3
St. Ward)

2. FULL NAME

Remon Roy Klier

(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. 1 mos. 13 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Infant

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

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

Dec 29-1932

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, hrs. min.

1

13

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)

Webster Co

10. NAME OF FATHER

Remon F. Klier

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Webster Co

12. MAIDEN NAME OF MOTHER

Mellie Bonnell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Webster Co

14.

INFORMANT (Address)

Remon F. Klier
Webster Co.

15.

FILED 2-13, 1933

John W. Good
me
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 12 - 1933

17. I HEREBY CERTIFY, That I attended deceased from
....., 1933, to

that I last saw h. im alive on 2-14, 1933, and that death occurred, on the date stated above, at 9:00 A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

HB Influenza (abstine)

HB

(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

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C.O.H. Williams, M. D.

2-14-1933 (Address) Fordland 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

DATE OF BURIAL

Gentry

Feb-13-1933

20. UNDERTAKER

C.F. Staw

ADDRESS

Fordland

WRITE 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.

RESERVED FOR BINDING

