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.

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

Do not use this space.

DEC 3 1936

791

42580

11087

1. PLACE OF DEATH

County..... Registration District No. 1003

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

City St. Louis, (No. City Hospital No.1 St. ..... Ward)

File No.....

Registered No.....

B. 11190

2. FULL NAME William Klages

(a) Residence, No. 1613 Carroll St., 23 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)
male	white	married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 25, 1880

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
56	9	8	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. street Department

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

FATHER

13. NAME William Klages

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER

15. MAIDEN NAME Annie Rapp

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Hosp. Info. M.H.Kent
(ADDRESS) City Hospital No.1

18. BURIAL, CREMATION, OR REMOVAL
PLACE New Picker DATE Nov 7 1936

19. UNDERTAKER John P. Coccia & Bro
(ADDRESS) 2728 Ivy

20. FILED ..... 19.....
J. J. Bredeck
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/3/36, 19

22. I HEREBY CERTIFY, That I attended deceased from 10/30/36, 19..., to 11/3/36, 19...

I last saw him alive on 11/3/36, 19... Death is said to have occurred on the date stated above, at 9.40 p m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar pneumonia	
Other contributory causes of importance:	

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury.....19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) William S. Friedewald, M. D.

(Address) City Hospital No.1