

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

REC'D APR 12 1939

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

791  
1003

8171  
Do not use this space.

1936

1. PLACE OF DEATH

(a) County.....  
(b) Township.....  
(c) City St. Louis (d) Street No. 14th Hazard St. St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 452 Otto K. Klinger St. 21 (If nonresident, give city or town and State)  
1436 Hazard St.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male  
4. COLOR OR RACE Wh  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Carolina  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 7 1867  
7. AGE YEARS 71 MONTHS 7 DAYS 30 If LESS than 1 day, hrs. or min.  
8. Trade, profession, or particular kind of work done, as a sawyer, bookkeeper, etc. Broer  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) 1937  
11. Total time (years) spent in this occupation 56

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

FATHER 13. NAME Jacob Klinger

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

MOTHER 15. MAIDEN NAME Maria Hammer

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

17. INFORMANT (ADDRESS) Otto K. Klinger  
1436 Hazard St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Catholic May 30, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John F. Strauss  
1225 Olive Blvd.

20. FILED MAR 1 1939 J. F. Budick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) APR 27 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at..... m.

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

Cerebral hemorrhage  
apoplexy

Other contributory causes of importance:

gza

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

What test confirmed diagnosis?..... Was there an autopsy? No

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? No

If so, specify..... (Signed) John F. Strauss M.D.

(Address) 1225 Olive Blvd.

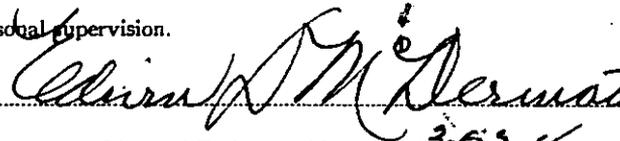
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....



Licensed Embalmer No.....

302K

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)**

**- If this body is not embalmed, above space should be left blank.**