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.

REC'D MAY 10 1939

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

12825
Do not use this space.

2 731

1. PLACE OF DEATH
(a) County ..... Registration District No. ..... 1003 Registered No. 3167
(b) Township ..... Primary Registration District No. ..... 1
(c) or City St. Louis Mo. (d) Street No. 2234a Jules 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 420 William Klaus
(a) Residence, No. 2234a Jules St. 23
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 20, 1855

7. AGE ~~84~~ YEARS 83 MONTHS 7 DAYS 13 If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
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)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo. 0

FATHER
13. NAME Stephan Klaus
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 6

MOTHER
15. MAIDEN NAME Helen Olliges
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Rose Klaus 2234a Jules Street

18. BURIAL, CREMATION, OR REMOVAL PLACE SS. Peter&Paul DATE 4/5/39, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. H. Gebken Und. Co 2630 Gravois Sv.

20. FILED APR 4 1939 J. F. Budick Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 2, 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1938, to Apr 2, 1939
I last saw him alive on Apr 2, 1939. Death is said to have occurred on the date stated above, at 4:30 p.m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Chronic Myocarditis | |
| Other contributory causes of importance: | |
| Parkinsons Disease | 1 yr |
| Senility | |

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) H M Kinner, M. D.
(Address) 3014 S. Jefferson

(Licensed Embalmer's Statement on Reverse Side)

## 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 Herman A. Gebken

Licensed Embalmer No. 2120

P. O. Address.....

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

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