

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

25191;
 Do not use this space.

AUG 7 1939

1. PLACE OF DEATH
 (a) County Caldwell Registration District No. 99
 (b) Township _____ Primary Registration District No. 7055 Registered No. _____
 (c) City Breckenridge (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred 43 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME William Charles Klein
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Leva Klein</u>			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)			
7. AGE	YEARS <u>64</u>	MONTHS <u>3</u>	DAYS <u>28</u>
	If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Retired Hotel Prop.</u>		
	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) <u>Pleasantburg, Missouri</u>			
FATHER	13. NAME <u>Henry Klein</u>		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>		
MOTHER	15. MAIDEN NAME <u>Elizabeth Schott</u>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis, Missouri</u>		
17. INFORMANT (ADDRESS) <u>Leva Klein, Breckenridge, Missouri</u>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Masonic Cemetery, Pleasantburg, Colorado</u> DATE <u>July 29, 1939</u>			
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>T. F. McPeck & Son, Breckenridge, Missouri</u>			
20. FILED <u>Aug 4, 1939</u> <u>A. C. Mearns, M.D.</u> Local Registrar			

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from July 26, 1939, to July 27, 1939. I last saw him alive on July 27, 1939. Death is said to have occurred on the date stated above, at 9 a.m.

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

Other contributory causes of importance:
Arthritis deformans for past 20 years. Hip invalid.

Name of operation none Date of _____
 What test confirmed diagnosis? Autopsy Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury 1939
 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) E. A. Thompson, M. D.
 (Address) Breckenridge, Mo.

Date of onset About 20 years ago

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.

RECEIVED
DEPT. OF
HEALTH
DIVISION

AUG 5 1939

839-948

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 *F. M. Beck*

Licensed Embalmer No. ~~15~~ 15

P. O. Address *Bree Kewndg*

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

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

25-191
Do not use this space.

1. PLACE OF DEATH
 (a) County Caldwell Registration District No. 94
 (b) Township _____ Primary Registration District No. 4053 Registered No. _____
 (c) City Breckenridge (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 William Charles Klein
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 27 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 3 28

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 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) _____

FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Aug 4 19 39 A. R. Wilsey Mod
 Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-27-39

22. I HEREBY CERTIFY, That I attended deceased from _____ 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:

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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) E. A. Thompson, M. D.
 (Address) Breckenridge, Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-25191 1939