

STANDARD CERTIFICATE OF DEATH

State File No. 35729

Registration District No. 107

Primary Registration District No. 3025

Registrar's No. 84

1. PLACE OF DEATH:

(a) County Linn  
 (b) City or town Brookfield  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
629 N. Monroe St.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community 4.5 years years, months or days)

3. (a) PRINT FULL NAME FREDERICK HUGO KLEIN

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ida Bander 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Feb. 21, 1864  
 (Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 24 If less than one day hr. min.

9. Birthplace Bismarck, Germany  
 (City, town, or county) (State or foreign country)

10. Usual occupation Shoemaker

11. Industry or business self

12. Name Not known

13. Birthplace Not known Germany  
 (City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Germany  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ida R. Klein  
 (b) Address Brookfield, Mo.

17. (a) Burial (b) Date thereof 10-18-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director Rust Funeral Home  
 (b) Address Brookfield, Mo.

19. (a) 10/17/40 (b) Spencer L. Sauer  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn  
 (c) City or town Brookfield  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 629 N. Monroe  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 63 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15  
 year 1940 hour 2 minute 30 a.m.

21. I hereby certify that I attended the deceased from April 16  
1936, to Oct 15, 1940  
 that I last saw him alive on Sept 24, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris  
 Due to Arteriosclerosis (General)  
 Due to Hypertension (vascular)  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings: 94 W  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration 270  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Y  
 While at work? \_\_\_\_\_ (Specify type of place)  
 (a) Means of injury \_\_\_\_\_  
 23. Signature H. H. Patten (M. D. or other) D.O.  
 Address Brookfield, Mo. Date signed 10/12/40

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.

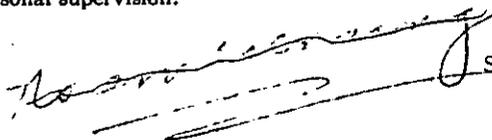
SEP 18 1944

**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.....

2718

P. O. Address.....

Brookfield, Mo

**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.**