

FILED OCT 14 1944

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution. _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede
(c) City or town Lebanon 53
(If outside city or town limits, write "RURAL") 1
(d) Street No. _____ (If rural, give location) 2
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Caroline Sue Klein

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 11 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 3 hr. _____ min.

9. Birthplace Lebanon Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER { 12. Name Wayne J. Klein
13. Birthplace Iowa (City, town, or county) (State or foreign country)
14. Maiden name Ruth K. Howell
15. Birthplace Laclede Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Albert Howell
(b) Address Lebanon Mo

17. (a) Burial (b) Date thereof 9-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Balles Cemetery

18. (a) Signature of funeral director No Funeral Director
(b) Address _____

19. (a) Oct-2-44 (b) Grace Pope
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11
year 1944 hour 5 minute 50 P.M.

21. I hereby certify that I attended the deceased from 9-11-1944 to 9-11-1944
that I last saw her alive on 9-10-44 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? _____

(Specify type of place) _____ (e) Means of injury _____

23. Signature R. E. Howell (M. D. or other) MD
Address Lebanon Mo Date signed 9-20-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Received
Laclede County Health Unit
File No. 9-44-128
Date Filed 10/11/44

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 Dorsey M. Howe
Licensed Embalmer No. 4222
P. O. Address Lebanon, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31224

Registration District No. 170

Primary Registration District No. 2023

Registrar's No. _____

1. PLACE OF DEATH: Toledo
 (a) County _____
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Carolins S. Klein
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 11 1944
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept year 1944 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____
 Due to congenital debility
 Due to 158
 Other conditions _____ (include pregnancy within 3 months of death)

PHYSICIAN _____
 Major findings: Of operations _____
 Of autopsy _____
 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature R.E. Harrell (M. D. or other) MD
 Address Toledo Mo Date signed 10-20-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

