

**FILED JAN 20 1945**  
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **257**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3902 Bates St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_

3. (a) PRINT FULL NAME Joseph P. Klein

3. (b) If veteran, name war No.

3. (c) Social Security No. No.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna J.

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 6 1875  
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

11. Industry or business John Klein

12. Name John Klein

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

14. Maiden name Unknown

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

16. (a) Informant Anna J. Klein

(b) Address 3902 Bates St.

17. (a) Cremation (b) Date thereof Jan. 12, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Walter Helderle  
3634 Gravois Ave.

(b) Address \_\_\_\_\_

19. (a) JAN 10 1945 J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3902 Bates St.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 9  
year 1945 hour 4 minute 15 A. M.

21. I hereby certify that I attended the deceased from Dec. 11, 1944 to Jan. 9, 1945  
that I last saw him alive on Jan. 9, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis Duration 2 hrs

Due to Chronic Myocarditis

Due to Arterio-Sclerosis

Other conditions 9 30  
(Include pregnancy within 3 months of death)

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury

23. Signature A W Peters (M. D. or other) M.D.

Address 4145 a S. Grand B. vd. Date signed 1/9/45

**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..... *Frank J. Maud*  
Licensed Embalmer No..... *2675*  
P. O. Address..... *St Louis 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.**