

7. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36871

FILED JAN 16 1945

1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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: Barnes Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 56 days (Specify whether years, months or days)

In this community \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town Chicago  
(If outside city or town limits, write "RURAL")

(d) Street No. 320 Plymouth Court  
(If rural, give location)

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

3. (a) PRINT FULL NAME Sol Kline

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

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

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

7. Birth date of deceased June 29 1870  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2<sup>nd</sup> year 1945 hour 9 minute 45 P. M.

21. I hereby certify that I attended the deceased from November 7 1945 to January 2 1945 that I last saw him alive on January 2 1945 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>6</u>	<u>4</u>	_____ hr. _____ min.

Immediate cause of death Hodgkins disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation Merchant

11. Industry or business Ready-to-wear

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy none performed

MOTHER, FATHER

12. Name Joseph Kline

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

14. Maiden name Sophie Baer

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Sidney Salkey

(b) Address 6457 Cecil

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-4-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Chicago, Ill.

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? \_\_\_\_\_

(a) Signature of funeral director H. Rindtke

(b) Address 5216 Delmar Blvd.

19. (a) JAN 4 1945 (Date received local registrar) (b) J. R. Burdick (Registrar's signature)

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

Means of injury \_\_\_\_\_

23. Signature James F. Jagg (M. D. \_\_\_\_\_)

Address Barnes Hospital Date signed 1/6/45

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

179

999  
11  
NR 0

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**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.....

*A. J. Burgess*

Licensed Embalmer No.....

*4029*

P. O. Address.....

**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.**