

FILED OCT 23 1945

STANDARD CERTIFICATE OF DEATH

State File No. 32746

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4137

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Gen Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)
In this community 28 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. is Locust at James Hotel
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Joseph Frank Klein
3. (b) If veteran, name war NO
3. (c) Social Security No. 500-14-8407

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 6
year 1945 hour 7:30 minute 8 M.

21. I hereby certify that I attended the deceased from Coron 19____ to ____ 19____
(that I last saw h. alive on ____ 19____
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race wh
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Hanna E Klein
6. (c) Age of husband or wife if alive 22 years
7. Birth date of deceased Jan 14 1874
(Month) (Day) (Year)

Immediate cause of death Cerebral Thrombosis

8. AGE: Years 71 Months 8 Days 22 If less than one day hr. min.

Due to _____
Due to _____

9. Birthplace Switzerland 5
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 83B

11. Industry or business Baker

Major findings: Of operations _____

12. Name Joseph Klein
13. Birthplace Switzerland 5
(City, town, or county) (State or foreign country)
14. Maiden name unmarried
15. Birthplace Switzerland
(City, town, or county) (State or foreign country)

Of autopsy yes - as above

16. (a) Informant Joseph E Klein
(b) Address 1872 Arlington Ind

22. If death was due to external causes, fill in the following:

17. (a) _____ (b) Date thereof 10-8-45
(Burial, cremation or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hills

(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? _____

18. (c) Signature of funeral director Stine McClure
(b) Address Kansas City Mo.

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

19. (a) 10-8-45 (b) Gertrude Holmes
(Date received local registrar) (Registrar's signature)

23. Signature John Walker (M. D. or other) Car
Address 1424 Prof Bldg Date signed 10-7-45

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

8
3
8

3
8
0

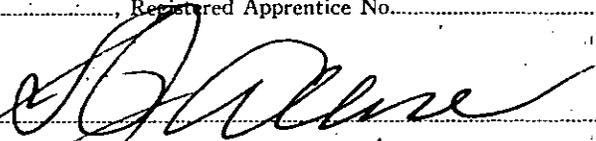
MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

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. 1415

P. O. Address. 15 e m

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.