

S. No. 2
M-5-43
7. 5-17-39
I X36671

FILED MAR 31 1947
318

1003

State File No. _____
Registrar's No. 2874

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
DE PAUL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 DAYS
(Specify whether years, months or days)

In this community 40 YEARS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 2716 BELT AVE
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME RUDOLPH L. KLEIN

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 WIDOWED

6. (b) Name of husband or wife ELIZABETH (c) Age of husband or wife if alive _____ years

7. Birth date of deceased APRIL 10 - 1867
(Month) (Day) (Year)

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

79	11	6	hr. min.
----	----	---	----------

9. Birthplace ST. MARKS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED R.R. CLERK

11. Industry or business FISCO. R.R.

MOTHER FATHER

12. Name FRANK KLEIN 0

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

14. Maiden name ANNA THOMAS 3

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

16. (a) Informant FLORENCE KLEIN

(b) Address 2716 BELT

17. (a) BURIAL (b) Date thereof MAR 20 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Cullen Kello

(b) Address MAR 4 1947 LINDSEY

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 16th
year 1947 hour _____ minute 9 P.M.

21. I hereby certify that I attended the deceased from Mar 12 to Mar 16, 1947
that I last saw him alive on Mar 16, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Left Heart Failure
Bronchitis - Pneumonia

Due to _____

Due to Senility 93

Other conditions Senility 93
(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) _____
Means of injury _____

23. Signature Robert J. Farnell (M. D. or other) _____
Address 624 N. Union Date signed 3/17/47

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

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.....

Albert Masfield

Licensed Embalmer No.....

3077

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.