

FILED SEP 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29033

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2059

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Koch, Mo</u>	c. LENGTH OF STAY (In this place) <u>803 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis 2259</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>25 1616 Franklin</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u> b. (Middle) _____ c. (Last) <u>KLINE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 27 1950</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>5/30/87</u>	9. AGE (In years last birthday) <u>63</u>	10. IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life) (even if retired) <u>Bill pebble</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Boonville, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Charles Kline</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>	14. NAME OF HUSBAND OR WIFE <u>Reatha Smith (deceased)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>N11</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Oscar Kline-Boonville, Missouri</u>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs approx</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic pulmonary tuberculosis</u>		331XA	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from July 1, 1950, to Aug. 27, 1950, that I last saw the deceased alive on Aug. 27, 1950, and that death occurred at 10:50 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Ellis J. Lisant M.D.</u> (Degree or title)	23b. ADDRESS <u>Koch Hosp., Koch, Mo.</u>	23c. DATE SIGNED <u>8/28/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-30-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Boonville, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>8-28-50</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>	ADDRESS <u>4700 Washington Blvd</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4000

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 _____

..... Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed *J. Wm. Binkley*

Licensed Embalmer No. *73253*

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.