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THE DIVISION OF HEALTH OF MISSOURI

FILED AUG 2 - 1955

STANDARD CERTIFICATE OF DEATH

State File No. **23980**  
Registrar's No. **5494**

**318**

**1003**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>St. Louis,</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>		f. STREET ADDRESS (If rural, give location) <b>534 N. Vandeventer</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>JOHN</b>	b. (Middle) <b>Hayden</b>	c. (Last) <b>KLEIN</b>	4. DATE OF DEATH	(Month) <b>JUNE</b>	(Day) <b>22,</b>	(Year) <b>1955</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced 3</b>	8. DATE OF BIRTH <b>May 30, 1882</b>	9. AGE (In years last birthday)	<b>73</b>	IF UNDER 1 YEAR	IF UNDER 11 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Desk Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Chester, Illinois,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13a. FATHER'S NAME <b>Peter Frederick Klein</b>	13b. MOTHER'S MAIDEN NAME <b>Laura Toney</b>	14. NAME OF HUSBAND OR WIFE <b>Josephine</b>
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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) <b>No.</b>	16. SOCIAL SECURITY NO. <b>496-18-801B</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. O.C. Patterson,</b>	ADDRESS <b>204 N. 2nd</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION <b>Keokuk, Iowa</b>		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Broncho pneumonia</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral Vascular Accident</b> DUE TO (c) <b>Arteriosclerosis</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <b>331x</b>
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22. I hereby certify that I attended the deceased from **6-17-55**, 19**55**, to **6-22-55**, 19**55**, that I last saw the deceased alive on **6-22-55**, 19**55**, and that death occurred at **11:30Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Richard J. Dames MD</b>	23b. ADDRESS <b>1515 Lafayette Avenue</b>	23c. DATE SIGNED <b>6-23-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>6-24-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oakdale Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Keokuk, Iowa</b>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	ADDRESS <b>4700 Washington.</b>
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7780 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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~~ ....., Student Embalmer No. .... working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *Christopher Penelias* .....

Licensed Embalmer No. *428*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.