

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035515

FILED VS OCT 5 1960

Registration District No. 209 Primary Registration District No. \_\_\_\_\_ Registrar's No. 51

STATE FILE NUMBER

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MARION</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>MARION</u> |  |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>WARREN TOWNSHIP</u>  |  | Length of stay in 1b<br><u>80 Yrs</u>   |  | c. CITY OR TOWN <u>RURAL</u>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>PHILADELPHIA MO R.F.D.</u>   |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><u>PHILADELPHIA, MO</u>  |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>GEORGE HENRY KLEIN</u>  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>SEPT 27, 1960</u>                           |   |  |  |   |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>12-12-1879</u>   | 9. AGE (last birthday)<br><u>80</u>                                    | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>FARMING</u>   |  | 11. BIRTHPLACE (City and state or country)<br><u>MARION COUNTY, MO</u>  |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>   |   |
| 13a. FATHER'S NAME<br><u>CHRISTOPHER KLEIN</u>   |  | 13b. MOTHER'S MAIDEN NAME<br><u>KATHERINE ORT</u>   |  | 14. NAME OF HUSBAND OR WIFE<br><u>BERTHA KLEIN</u>  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>Mr. Bertha Klein</u>  |  | Address<br><u>Philadelphia mo</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>DUE TO (b) <u>Hypertension</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |  |   |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> N: <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/>  | HOMICIDE <input type="checkbox"/>  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.  | Month, Day, Year                       |   |  |   |  |  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>NOT WHILE AT WORK <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 20f. CITY, TOWN, OR LOCATION  |  | COUNTY   | STATE   |
| 21. I attended the deceased from <u>Sept 24</u> to <u>Sept 26</u> and last saw her/him alive on <u>Sept 26, 1960</u><br>Death occurred at <u>9:15 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |   |  |  |   |
| 22a. SIGNATURE<br><u>P.H. Stukeman MD</u> (Degree or title)  |  |   |  | 22b. ADDRESS<br><u>Bellevue Mo</u>  |  | 22c. DATE SIGNED<br><u>9-28-60</u> (State)   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE<br><u>9-29-60</u>            | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ANDREW CHAPEL</u>  |  | 23d. LOCATION (City, town, or county)<br><u>MARION COUNTY, MO</u>   |  |  |   |
| 24. FUNERAL DIRECTOR<br><u>Wilson &amp; Son</u>  |  | ADDRESS<br><u>Memorial Bldg</u>   |  | 25. DATE RECD. BY LOCAL REG.<br><u>9-28-60</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Dr. E.M. Lude, by Viola Gar Deputy</u> |  |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 11 130

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by me, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lucie L. Wilson

Licensed Embalmer No. 3014

P. O. Address Monroe City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.