Indiana State Board of Health
CERTIFICATE OF DEATH

PUNCHED

Registered No. 29216

PLACE OF DEATH
County of Wabash
Township of
Town of Noble
or
City of Wabash (No. 494 N Comstock St., Ward) [If death occurred in a Hospital or Institution, give its NAME instead of street and number.]

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information"]

FULL NAME Charles Oscar Klinger

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male
Color or Race: White
Single, Married, Widowed or Divorced (Write the word): Married

NAME OF HUSBAND OR WIFE (of deceased): Carrie Klinger

DATE OF BIRTH (of deceased): 11 (Month) 8 (Date) 1869 (Year)

AGE: 58 years 10 months 8 days. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Baker
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE OF DECEASED (state or country): Indiana

PARENTS
NAME OF FATHER: Samuel Klinger
BIRTHPLACE OF FATHER (State or country): Ohio
MAIDEN NAME OF MOTHER: Lida Hector
BIRTHPLACE OF MOTHER (State or country): Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Carrie Klinger
(Address) Wabash Ind

Filed Sept. 18 1928 D. H. Gressor, Wabash Ind
Name and Address of Health Officer or Deputy

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept (Month) 16 (Day) 1928 (Year)

I HEREBY CERTIFY, That I attended deceased from August 1928 to Sept 16 1928
that I last saw him alive on Sept 15 1928
and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Hepatic Carcinoma
HD (Duration) ___ yrs. 9 mos. ___ ds.

Contributory (Secondary)
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W. S. Gordon, M.D.
Sept 17, 1928 (Address) Wabash Ind

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted, if not at place of death?
Former or Usual Residence

PLACE OF BURIAL OR REMOVAL: Wabash Ind
DATE OF BURIAL: 9-18 1928
UNDERTAKER: Homer E. Grover
WAS THE BODY EMBALMED? yes
ADDRESS: Wabash Ind.
EMBALMER'S LICENSE No. 1770

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. The "Special Information" for persons away from home should be given in every instance.

A GOOD BODY BURIAL WITHOUT A PERMIT SHALL BE DISINTERRED AND REQUEST HELD