

MAY 19 1936

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

15311

## 1. PLACE OF DEATH

County Jackson  
Township Kaw  
City Kansas City

Registration District No. 399  
Primary Registration District No. 1002  
(No. St. Mary's Hosp.)

File No. \_\_\_\_\_  
Registered No. 24228  
St. 2028 Ward

2. FULL NAME Chas. J. Klassen(a) Residence, No. 5336 Harrison St., \_\_\_\_\_ Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Ma. 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Hannah Klassen

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr. 26th, 1865-1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

65 11 19

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Data13. NAME Theodore Klassen14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Data15. MAIDEN NAME No Data16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Data17. INFORMANT Miss Louise Klassen (ADDRESS) 5336 Harrison18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE 4-18 193619. UNDERTAKER W. F. Mayberry (ADDRESS) City20. FILED Apr 23 1936 M. M. Brown Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 15th, 1936

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at 5:15 P.m.

The principal cause of death and related causes of importance were as follows:

Carcinoma of esophagus Date of onsetArise into Aortic ArchEsophageal Remission

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

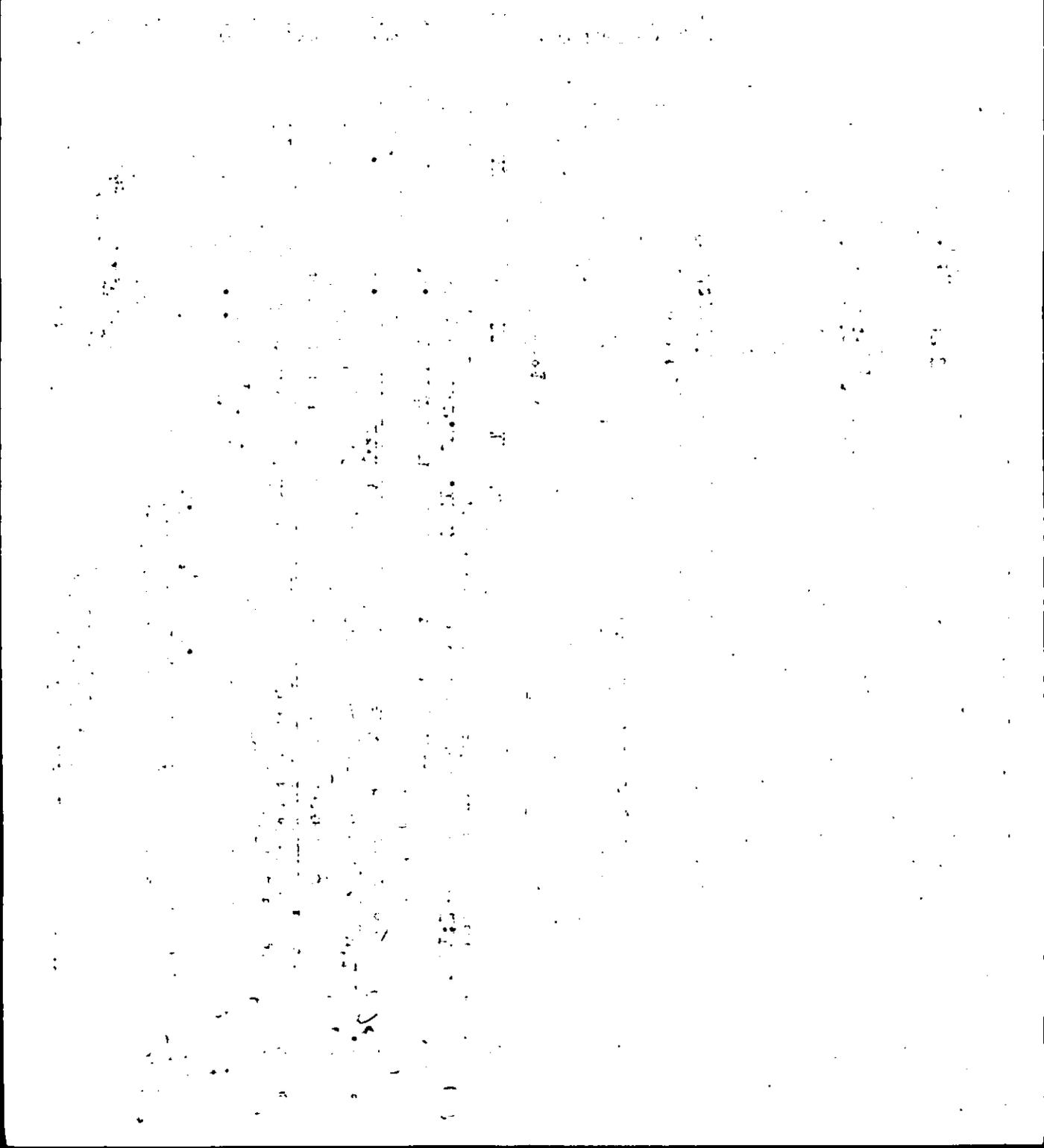
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) A. B. Eubank, M. D.(Address) 636 Argyle Bldg

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. Exact statement of OCCUPATION is very important.



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County..... Registration District No.....  
Township..... Primary Registration District No.....  
City..... (No. *St. Mary*)..... St. .... Ward)

File No.....  
Registered No. *2028*

**2. FULL NAME**

*Charles J. Klassen*  
(a) Residence, No. .... St. .... Ward. ....  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *M* 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS *65* LESS than 1 day, .... hrs. or .... min.

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year).....  
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER  
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED *4/16* 19 *36* *M. M. Brown* Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4-15-1936*

22. I HEREBY CERTIFY, That I attended deceased from *January*, 19 *36* to *April*, 19 *36*

I last saw him alive on *April 15*, 19 *36* Death is said to have occurred on the date stated above, at *P.* m.

The principal cause of death and related causes of importance were as follows:

**Carcinoma of the esophagus.**

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? **Yes.**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **No.** If so, specify.....

(Signed) *A. E. E. E. E.* M. D.

(Address) *636 A. E. E. E. E.*

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. Exact statement of OCCUPATION is very important.

S-15311