

DECD FEB 20 1939

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

1243  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. 631 East 60th St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

451 Mrs. Elizabeth C. Kleinhoffer  
 (a) Residence, No. 631 East 60th Street St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Laurence Kleinhoffer  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 6, 1887  
 7. AGE YEARS 56 MONTHS 7 DAYS 13 If LESS than 1 day, hrs. or min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-19-39, 19  
 22. I HEREBY CERTIFY, That I attended deceased from 9:00 P.M.  
 I last saw him alive on 1-19-39 Death is said to have occurred on the date stated above, at 9:00 P.M.  
 The principal cause of death and related causes of importance were as follows:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Mo.  
 13. NAME Jacob Brucker  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fort Wayne Indiana  
 15. MAIDEN NAME Margaret Lauer  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fort Wayne Indiana  
 17. INFORMANT (ADDRESS) Miss Clara Kleinhoffer  
631 East 60th St  
 18. BURIAL, CREMATION, OR REMOVAL PLACE St. Mary's Cem. DATE Jan. 23, 1939

Fungating colloid carcinoma of its transverse colon  
Perforation of transverse colon at site of carcinoma  
 Other contributory causes of importance:  
Acute generalized peritonitis  
 Date of onset 1/19/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) QUIRK & TOBIN  
Kansas City, Mo.  
 20. FILED Jan 21, 1939 M. M. Gross  
Local Registrar.

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? U  
 If so, specify.....  
 (Signed) Paul H. Brucker, M. D.  
 (Address) Gen Hosp. H. C. Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

---

---

**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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, above space should be left blank.**