

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.

*Bosman*  
 SEP 12 1939

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

28930  
 Do not use this space.

1. PLACE OF DEATH

(a) County Cole Registration District No. 213  
 (b) Township Jefferson Primary Registration District No. 3014 Registered No. 193  
 (c) City Jefferson City, Mo. (d) Street No. St. Mary's Hospital 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. da.

2. PRINT FULL NAME Danial Henry Kloppel

(a) Residence, No. Freeburg, Mo. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 9, 1937

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>2</u>	<u>2</u>	<u>12</u>	<u>12</u>

OCCUPATION

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

9. Industry or business in which work was done, as saw mill, bank, etc. none

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Westphalia, Mo. (STATE OR COUNTRY)

FATHER

13. NAME Fred F. Kloppel

14. BIRTHPLACE (CITY OR TOWN) Richfountain, Mo. (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME Hilda Falter

16. BIRTHPLACE (CITY OR TOWN) Freeburg, Mo. (STATE OR COUNTRY)

17. INFORMANT Fred F. Kloppel (ADDRESS) Freeburg, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Freeburg, Mo. DATE 8/23/39

19. FUNERAL DIRECTOR (NAME) John E. Heinrichs (ADDRESS) Jefferson, City, Mo.

20. FILED 8/22/1939 Bosman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/21/39

22. I HEREBY CERTIFY, That I attended deceased from Aug. 17 1939 to Aug 21 1939  
 I last saw him alive on Aug 21 1939. Death is said to have occurred on the date stated above, at 6:40 P.M.  
 The principal cause of death and related causes of importance were as follows:  
General Peritonitis  
caused by  
Ruptured Appendix  
 Date of onset Aug 14, 1939

Other contributory causes of importance:  
Pneumonia 121 Aug 16, 1939  
Abdominal drainage Aug 17, 1939

Name of operation Abdominal drainage Date of operation Aug 17, 1939

What test confirmed diagnosis? 1716 Was there an autopsy? 1716

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) Bosman M. D.  
 (Address) Jefferson City, Mo.

**STATEMENT BY LICENSED EMBALMER**

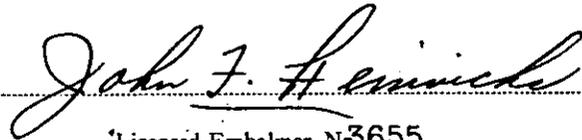
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

**John F. Heinrichs**

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



..... Licensed Embalmer No **3655**.....

P. O. Address **Jefferson City, Mo.**.....

**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.**