

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson PCT 18 1939 2
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3811 State Line
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days) 50 years

3. (a) PRINT FULL NAME Henry Klomp 451

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna Klomp 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased May 2 1861
(Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace Kleve Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Shipping Clerk (Retired)

11. Industry or business Wm. Volker & Co. 6

MOTHER FATHER { 12. Name Bart Klomp

13. Birthplace Germany 6
(City, town, or county) (State or foreign country)

14. Maiden name No Record 6

15. Birthplace Germany 6
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. D. J. McCarthy
(b) Address 4440 Fairmount

17. (a) Burial (b) Date thereof Sept. 22-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Mary's John W. Wagner
(a) Signature of funeral director Kansas City, Mo.
(b) Address Sept 20 1939 (c) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3811 State Line
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 50 years years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19
year 1939 hour 7 minute 20 P. M.

21. I hereby certify that I attended the deceased from Sept 16/39
to Sept 19 1939
that I last saw him alive on Sept 19 and that death occurred on the date and hour stated above.

Immediate cause of death: Cor Arterio Sclerosi
Chr Hypertens
Due to _____

Duration 10 yrs

Due to 131
Other conditions Artemia 4 days
(Include pregnancy within 3 months of death)

Major findings: All parts in Arterio Scleroses Arteries
Of operations _____
Of autopsy None

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____
(Specify type of place) (Specify type of injury)
28. Signature D. J. V. Dell (M. D. or other) 9/20/39
Address 1137 Professional Bldg Date signed 9/20/39
Kelec

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 *W. H. Haunschild*
Licensed Embalmer No. *4062*
P. O. Address *K. C. 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.