

Registration District No. 457

Primary Registration District No. 5621B

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Concordia Rural
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 68 year 4 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME W. KLEFFMANN

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 29 - 1871
(Month) (Day) (Year)

8. AGE: Years 68 Months 4 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace Concordia Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Karl Kleffmann
18. Birthplace Bermain
(City, town, or county) (State or foreign country)
14. Maiden name Anna Schmidt
15. Birthplace Bermain
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Anna Kleffmann

(b) Address Konradstrasse

17. (a) Rural (Burial, cremation, or removal) (b) Date thereof 4-1-40
(Month) (Day) (Year)

(c) Place: burial or cremation St Pauls Cemetery

18. (a) Signature of funeral director Fausting & Co

(b) Address Concordia Mo

19. (a) 3-30-40 (Date received local registrar) (b) Pedchison and Spryman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Freedom Township
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30
year 1940 hour 9 minute 0 M.

21. I hereby certify that I attended the deceased from March 26 1940, to March 29 1940, that I last saw her alive on March 29 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Inflammation Duration 4 days

Due to _____

Due to 118

Other conditions None
(Include pregnancy within 5 months of death)

PHYSICIAN

Major findings: Of operations _____
Of autopsy NT
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? 412
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Pedchison and Spryman (M. D. or other) _____
Address Concordia Mo. Date signed 3-30-40

WHILE FILLING IN USE WRITING BLACK INK—MAKE A PERMANENT RECORD

REV. 1-1-1931

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.

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 4-3-40

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 *ES Freking - FC Vaigt*
2919
Licensed Embalmer No. ~~1151~~ 1511

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.