

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24107**
Registrar's No. **2717**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City 2**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1105 E 59 home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

8. (a) PRINT FULL NAME **KLANN, Charles J**
3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **divorced**
7. (b) Name of husband or wife **Wife** (c) Age of husband or wife if alive **45** years
7. Birth date of deceased **Oct 14 - 1887**
(Month) (Day) (Year)

8. AGE: Years **53** Months **8** Days **22** If less than one day _____ hr. _____ min.

9. Birthplace **Deer Co. Mo.**
(City, town or county) (State or foreign country)

10. Usual occupation **fil boy contractor**

11. Industry or business **self**

12. Name **John Klamm**
13. Birthplace **Clay Co Mo**
(City, town or county) (State or foreign country)
14. Maiden name **Elizabeth Klamm**
15. Birthplace **Madison Co Mo**
(City, town or county) (State or foreign country)

16. (a) Informant **J. P. Schuman**
(b) Address **J. Parkville mo B#2**

17. (a) **Burial** (b) Date thereof **July 9, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Moriah, R. 5 Mo.**

18. (a) Signature of funeral director **Huddell**
(b) Address **6900 Ross St Remo**

19. (a) **July 7, 1940** (b) **M. H. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **1105 E 59th**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **American** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **9** year _____ hour _____ minute **8:37** M.

21. I hereby certify that I attended the deceased from _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Pulmonary Edema**

Other conditions (Include pregnancy within 3 months of death)
Major findings: **Chronic Pulmonary Edema**
Of operations **None**
Of autopsy **Inspector only**

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)
(e) Means of injury _____

23. Signature **Huddell** (M. D. or other) _____
Address _____ Date signed _____

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

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~~ *has*
been Formalin Packed with no Adherial Embalming Registered Apprentice No. _____
~~working under my personal supervision.~~

Signed *LW Hawthorne.*

Licensed Embalmer No. *3845.*

P. O. Address *6900 Frost. N.C.*

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.