

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28458

Registration District No. 292

Primary Registration District No. 2416

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Franklin  
 (b) City or town Catawissa Rural Calvey Township  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location) 2

- (d) Length of stay: In hospital or institution 8 months (Specify whether years, months or days) 1571

In this community 8 months (Specify whether years, months or days) 1571

8. (a) PRINT FULL NAME Henry Aug Klemme

3. (b) If veteran, name war no 8. (c) Social Security No. no

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

6. (b) Name of husband or wife Elizabeth Klemme 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

8. AGE: Years 79 Months 0 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Beemont MO.  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

12. Name Fredrick A. Klemme

18. Birthplace Unknown Germany  
 (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Beckman

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

16. (a) Informant Mrs. Margaret Mc Keefer

(b) Address Catawissa, Mo.

17. (a) Rural (b) Date thereof Aug. 26, 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Boeff Cemetery, Gerald Mo.

18. (a) Signature of funeral director E. J. Meyer

(b) Address Gerald, Mo.

19. (a) 8-26-40 (b) Mary Kross  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Gasconade

(c) City or town Catawissa, Rural  
 (If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. # 1.  
 (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 24  
 year 1940 hour 7.5 minute 30 p. M.

21. I hereby certify that I attended the deceased from 8/14 to 8/24 1940  
 that I last saw him alive on Aug 24 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
 Duration \_\_\_\_\_

Due to Hypotatic pneumonia 5 days

Due to \_\_\_\_\_

Other conditions Ashtenia, arteria  
 (include pregnancy within 3 months of death) Coronary

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?  
266 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. M. Mason (M. D. or other) \_\_\_\_\_

\*Address Pacific Date signed 8/24/40

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

6

AUG 19 1940  
 FILED SEP 19 1940

111 B

*Handwritten scribbles and marks*

*Handwritten scribbles and marks*

**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 Robert M Murray

Licensed Embalmer No. 37419

P. O. Address Owensville, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **28438**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **293**

Primary Registration District No. **5416**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Franklin**  
(b) City or town **Calvary, Ia.**  
(If outside city or town limits, write "RURAL" and name of township)  
(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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME **Henry Aug Klemme**

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

4. Sex **m** 5. Color or race **w**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years **79** Months **0** Days **20** If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **2** year **1970** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Bronchial Pneumonia**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **asthenia, arterio sclerosis**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy **107K**

Duration

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? \_\_\_\_\_

(Specify type of place) While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

