

Registration District No. **172**

Primary Registration District No. **3034**

1. PLACE OF DEATH:

(a) County **Lafayette**
(b) City or town **Higginsville, Mo.**
(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)

3. (a) PRINT FULL NAME **Mary A. Klapp**

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

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

6. (b) Name of husband or wife **Wm. A. Klapp (Deceased)** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **November 28th 1855**
(Month) (Day) (Year)

8. AGE: Years **86** Months **11** Days **29** If less than one day _____ hr. _____ min.

9. Birthplace **Mayview, Mo.** (City, town, or county) (State or foreign country) **0**

10. Usual occupation **House wife**

11. Industry or business _____

12. Name **John McElroy**
13. Birthplace **Virginia** (City, town, or county) (State or foreign country) **/**

14. Maiden name **Susan Pool**
15. Birthplace **Virginia** (City, town, or county) (State or foreign country) **/**

16. (a) Informant **Miss Pearl Klapp**
(b) Address **Higginsville, Mo.**

17. (a) **Higginsville** (b) Date thereof **11/29/42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Higginsville, Mo.**

18. (a) Signature of funeral director **W.A. Braecklein**
(b) Address **Higginsville, Mo.**

19. (a) **11-29-1942** (b) **W.A. Braecklein**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Lafayette**
(c) City or town **Higginsville**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **27**
year **1942** hour **7:30** PM minute _____ M.

21. I hereby certify that I attended the deceased from **Nov 17-42**
19____ to **Nov 28-42** 19____
that I last saw her alive on **Nov 27-42** 19____
and that death occurred on the date and hour stated above.
Immediate cause of death **Myocarditis (Chronic)** Duration _____

Due to **Old age & Arteriosclerosis**

Due to _____
Other conditions _____ (Include pregnancy within 3 months of death) **93d**

Major findings:
Of operations _____
Of autopsy _____
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 **W.A. Braecklein** (M. D. or other)
Address **Higginsville Mo** Date signed **11/28/42**

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

54
2
1

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 12-11-42

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 _____

Licensed Embalmer No. 4269

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, fact should be so stated above.