

**MAY 5 1943**  
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. ....

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community 1 Year  
years, months or days)

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. 4419 Harrison  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Hazel Klingensmith

3. (b) If veteran, name war NO 3. (c) Social Security No. 486-12-3678

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

6. (b) Name of husband or wife Harry Klingensmith 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased July 6 1941-1901  
(Month) (Day) (Year)

8. AGE: Years 41 Months 9 Days 5 If less than one day  
.....hr. ....min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Harry Klingensmith

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

14. Maiden name Maude Kelly

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

16. (a) Informant Harry Klingensmith

(b) Address 4419 Harrison

17. (a) removal (b) Date thereof 4-12-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ravanna Mo

18. (a) Signature of funeral director Mrs. C.L. Forsters

(b) Address 918 Brooklyn

19. (a) 4-12-43 (b) M. M. Corona  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11th  
year 1943 hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from 4-10-43, 19, to 4-11-43, 19, that I last saw her alive on 4-11-43, 19, and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculous Meningitis

Due to 14

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy See above

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 Dr. R. Jones (M. D. or other)  
Med Dir. K.C. Gen. Hospital  
Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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**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. *T*

Signed *Donald C. Browning*

Licensed Embalmer No. *2724*

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, fact should be so stated above.**