

FILED FEB 6 1945  
199

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 282

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

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 1550 E. 8th St. General Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 Hrs

In this community 6 Mo. 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 49

(c) City or town Kansas City 2  
(If outside city or town limits, write "RURAL")

(d) Street No. 1330 East 8th St. 5  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_ 11

3. (a) PRINT FULL NAME Sandra Kay Kloiber

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Femal 5. Color or race white

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 July 9 1944  
(Month) (Day) (Year)

8. AGE: Years 0 Months 6 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Infant

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

12. Name James Robert Kloiber

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

14. Maiden name Frances Mezzacasa

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

16. (a) Informant James R. Kloiber

(b) Address 1330 Est 8 St,

17. (a) Burial (b) Date thereof Jan. 19 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cem.

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

(b) Address 918 Brooklyn

19. (a) 1-18-45 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 17  
year 1945 hour 11:30 minute A M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 Broncho-pneumonia

Due to acute laryngitis

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Duration \_\_\_\_\_

Major findings: History + Inspection

Of operations \_\_\_\_\_

Of autopsy no

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 3

(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 N. E. Brown (M. D. or other) 17  
Address 1429 Poplar St Date signed 1-17-45

---

---

**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.....

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.**