S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 5 1945

Registration District No. 116

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9587

Primary Registration District No. 3020

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Franklin.

(b) City or town Washington.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 227 E. 5th St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None. (Specify whether
In this community 81 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town Washington 36
(If outside city or town limits, write "RURAL")

(d) Street No. 227 E. 5th St. 6
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country X

3. (a) PRINT FULL NAME Amanda Kloentrup.

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife X

6. (c) Age of husband or wife if alive X years

7. Birth date of deceased February (Month) 18th. (Day) 1864 (Year)

8. AGE: Years 81 Months 1 Days 12 If less than one day hr. min.

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

10. Usual occupation Retired Teacher.

11. Industry or business X

FATHER
12. Name J. Herman Kloentrup.
13. Birthplace Hanover. (City, town, or county) Germany. (State or foreign country)

MOTHER
14. Maiden name Eliza Korte.
15. Birthplace Hanover. (City, town, or county) Germany. (State or foreign country)

16. (a) Informant Mrs. C. B. Maune

(b) Address Union, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 2, 1945. (Month) (Day) (Year)

(c) Place: burial or cremation Washington, Mo.

18. (a) Signature of funeral director Nilburg & Vitt, Inc

(b) Address Washington, Mo.

19. (a) 3/31/45 (Date received local registrar) (b) Lucille R. Brooks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30th. year 1945 hour 11:00 minute 20 A.M.

21. I hereby certify that I attended the deceased from Mar. 18, 1942, to Mar 30, 1945; that I last saw her alive on Mar 30th, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic myocarditis	4 yrs.
Due to unknown	
Due to 93d	
Other conditions (Include pregnancy within 3 months of death)	

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 E. C. Finnie (M. D. or D. O.)

Address Washington Mo. Date signed 3/31/45

1181

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 4-4-45

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 Lester H. Cutt

Licensed Embalmer No. 3254

P. O. Address Washington, 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.