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5-17-39  
X37823

FILED JUN 7 1946 STANDARD CERTIFICATE OF DEATH

State File No. 17160

Registration District No. 171

Primary Registration District No. 5637

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Lafayette Clay Township  
(b) City or town Odessa Rural  
(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 5 Das.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Clay Twns.  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME

John Klotz

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M O

5. Color or race W

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 August 17 1859  
(Month) (Day) (Year)

8. AGE: Years 87 Months 8 Days 25  
If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name Henry K. Klotz  
13. Birthplace Germany  
14. Maiden name Not known  
15. Birthplace " " }

16. (a) Informant Hattie Klotz  
(b) Address Napoleon, Mo.

17. (a) Burial (b) Date thereof May 16, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arnold Cem. Wellington, MO.

18. (a) Signature of funeral director Husman-Sparks  
(b) Address Odessa, Mo.

19. (a) June 1, 1946 (b) Letta Drummond  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12  
year 1946 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 9, 1946, to May 12, 1946, that I last saw him alive on May 12, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis  
Nephritis (interstitial)  
Hypertension

Duration

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

RECEIVED INFORMATION SUPPLEMENTARY INVESTIGATION

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?

While at work? (Specify type of place) (c) Means of injury

23. Signature J. C. Choate (M.D. or other) Date signed 5/15/46  
Address Odessa, Mo.

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

6-6-66

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

*W. J. Sparks*

Registered Apprentice No.

*385*

working under my personal supervision.

Signed

*Irving L. Husman*

Licensed Embalmer No.

*7541*

P. O. Address

*W. J. Sparks, Inc.*

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.

Registration District No. 171

Primary Registration District No. 5637

July  
7

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Rural  
(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

John Klatz

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 3

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

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

8. AGE: Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

MOTHER FATHER { 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)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

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

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

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 2  
year 1946 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 \_\_\_\_\_

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

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

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

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

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

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? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

16041

SUPPLEMENTARY  
Chronic hepatitis

