

S. No. 2
DM-8-43
v. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26787**
Registrar's No. **84**

FILED SEP 3 1946
Registration District No. **776**

Primary Registration District No. **3020**

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:
ST. FRANCIS HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
In this community **entire life** years, months or days (Specify whether years, months or days)

3. (a) PRINT FULL NAME **JOHN F. KLINGSICK**
(b) If veteran, name war **no**
(c) Social Security No. **none**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (c) Age of husband or wife if alive **12 1868** years (Month) (Day) (Year)

7. Birth date of deceased **April 12 1868** (Month) (Day) (Year)
8. AGE: Years **78** Months **4** Days **8** If less than one day hr. min.

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

10. Usual occupation **Farming**

MOTHER FATHER
11. Industry or business
12. Name **Henny Klingsick**
13. Birthplace **Germany** (City, town, or county) (State or foreign country)
14. Maiden name **Blind**
15. Birthplace **Germany** (City, town, or county) (State or foreign country)
16. (a) Informant **Mrs. Fred Klingsick**
(b) Address **Leola Mo**
17. (a) **Buried** (b) Date thereof **9/2/46** (Month) (Day) (Year)
(c) Place: burial or cremation **Port Hudson La**
18. (a) Signature of funeral director **L. D. Wittig & Sons**
(b) Address **New Haven Mo**
19. (a) **8/30/46** (Date received by registrar) (b) **[Signature]** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **FRANKLIN**
(c) City or town **WESLIE (RURAL)**
(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 **8** day **30**
year **1946** hour minute M.
21. I hereby certify that I attended the deceased from **8-28**, 19**46** to **9-30**, 19**46**
and that death occurred on the date and hour stated above.
that I last saw him alive on **9-30**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Urinary Carcinoma of Bladder** Duration **6 Mo**

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **52K**
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?

While at work? (Specify type of place) (e) Means of injury
23. Signature **B.H. Stuhlman** (M. D. or other) **M.D.**
Address **Union Mo** Date signed **8-30-46**

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

36
6
2

25633

36
0
0
0

11
H.D.

RECEIVED
District Health Officer No. 9,
District File Number 8-46-230
Date Filed 8-31-46

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 me
....., Registered Apprentice No.....
working under my personal supervision.

Signed Carl C. Fertig
Licensed Embalmer No. 33085
P. O. Address New Haven, Conn.

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.