

S. No. 2
1-8-43
5-17-39
X37823

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 594

FILED JAN 29 1947

Primary Registration District No. 3016

Registrar's No. 18

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

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 1 week
years, months or days

3. (a) PRINT FULL NAME Wm. A Kleithermes

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

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

6. (b) Name of husband or wife ANNA MOSS 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Oct 14 1888
(Month) (Day) (Year)

8. AGE: Years 58 Months 3 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation Garage Foreman

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Kleithermes
13. Birthplace Loose Creek Mo
(City, town, or county) (State or foreign country)
14. Maiden name Mary Knoerr
15. Birthplace Rich Fountain Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Wm Kleithermes
(b) Address Linn Mo

17. (a) Burial (b) Date thereof 1-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Linn Mo

18. (a) Signature of funeral director Clyde Maston

(b) Address Linn Mo

19. (a) 1-20-47 (b) R. P. Davis M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 0) Bage
(c) City or town Linn Mo
(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 1 day 10
year 1947 hour 1 minute 45am

21. I hereby certify that I attended the deceased from at 3 years
... 19... to January 18 (18) 1947
that I last saw him alive on January 18 (18) 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Palate
Bi lateral cerebral metastasis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations 45C
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 0

23. Signature W. S. McKeally (M. D. or other) MD
Address Jefferson City Mo Date signed 1-20-47

M. S. Kennedy

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JAN 27 1947

FEB 13 1947

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 *Vernon M. Morton*

Licensed Embalmer No. *4125*

P. O. Address *Linn*

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.