

FILED OCT 13 1947
Registration District No. **1000**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County **Buchanan**

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

(c) Name of hospital or institution: **3105 Mitchell Ave.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **36 years**
(Specify whether years, months or days)

In this community **36 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**

(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")

(d) Street No. **3105 Mitchell Ave.**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Anna L. Kleber**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**

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

6. (b) Name of husband or wife **W. L. Kleber** 6. (c) Age of husband or wife if alive **83** years

7. Birth date of deceased **May 16 1869**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	78	4	17	hr. min.

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

10. Usual occupation **At home**

11. Industry or business **At home**

MOTHER FATHER

12. Name **Grabo**

13. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary**

15. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **W. L. Kleber**

(b) Address **St. Joseph, Mo.**

17. (a) **Burial** (b) Date thereof **10/6/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Auburn Cemetery**

18. (a) Signature of funeral director **Heaton Rowman**

(b) Address **St. Joseph Mo.**

19. (a) **10-8-47** (b) **C. G. Jenkins**
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **3**
year **1947** hour **10** minute **30** A. M.

21. I hereby certify that I attended the deceased from **12-6**
19 **46** to **9-29** 19 **47**
that I last saw him alive on **9-29** 19 **47**
and that death occurred on the date and hour stated above. Duration

Immediate cause of death **Atherosclerosis
Heart Disease
Calcium on the Arteries**

Due to _____

Due to _____

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: **None**

Of operations **None**

Of autopsy **None**

PHYSICIAN

Underline the cause of 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 working? _____ (e) Means of injury _____

23. Signature **Frederick J. Brunner** (M. D. or other) _____
Address **St. Joseph Mo.** Date signed **10-8-47**

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

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 James B. Hawkins, Registered Apprentice No. 27 working under my personal supervision.

Signed Eugene Wood

Licensed Embalmer No. 3864

P. O. Address 31950 10th St. Joseph, 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.