

FILED MAR 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8122

BIRTH NO. _____ REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 3017 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Moniteau	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Boonville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clarksburg 0680	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Ravensway Hospital		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) Relaford b. (Middle) William c. (Last) Klein			4. DATE OF DEATH (Month) (Day) (Year) Mar. 7 1950
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 12-1908
9. AGE (In years last birthday) 41		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (State or foreign country) Florence, Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Frederick Wm. Klein		13b. MOTHER'S MAIDEN NAME Mary Carver	14. NAME OF HUSBAND OR WIFE Lowell Thurman Klein
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. R.W. Klein, Clarksburg, Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION the I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inoperable Carcinoma of Cecum ANTECEDENT CAUSES Due to (b) Cecum Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Due to (c) II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Feb 23, 1950 , to Mar. 7, 1950 , that I last saw the deceased alive on Mar 6, 1950 , and that death occurred at 1:00 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Oliver Ravensway, M.D.		23b. ADDRESS Boonville, Mo	23c. DATE SIGNED 3-7-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-9-50	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) Sedalia, Missouri
DATE REC'D BY LOCAL REG. 3-8-50	REGISTRAR'S SIGNATURE Hooper 381	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Erving Duane Ewing, Sedalia, Mo.	

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

RECEIVED

MAR 20

MAR 22 1950

District Health Officer No. 8,

District File Number _____

Date Filed 3-21-50

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.