

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 193

1. PLACE OF DEATH <u>Ellis Fischel State Cancer Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY <u>Boone</u>		a. STATE <u>Missouri</u>	b. COUNTY <u>Stone</u>
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Reeds Spring</u>	
c. LENGTH OF STAY (In this place) <u>922 days</u>		1040	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Ellis Fischel State Cancer Hosp.</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED			4. DATE OF DEATH
a. (First) <u>Maude</u>	b. (Middle) <u>Delta</u>	c. (Last) <u>Klutts</u>	(Month) (Day) (Year) <u>July 5 1950</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>1</u>	8. DATE OF BIRTH <u>8-26-13</u>
9. AGE (In years last birthday) <u>36</u>		IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafe Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>W. H. Meeke</u>	
13b. MOTHER'S MAIDEN NAME <u>Nora Alice</u>		14. NAME OF HUSBAND OR WIFE <u>Leonard Klutts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Record</u>		ADDRESS	
18. CAUSE OF DEATH		MEDICAL CERTIFICATION	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma, uterine cervix</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		INTERVAL BETWEEN ONSET AND DEATH <u>3</u>	
II. ANTECEDENT CAUSES		DUE TO (b) <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>	
III. OTHER SIGNIFICANT CONDITIONS		DUE TO (c) _____	
Conditions contributing to the death but not related to the disease or condition causing death.		171X	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Only biopsy performed</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 <u>13 June</u> , 19 <u>50</u> , to <u>5 July</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>5 July</u> , 19 <u>50</u> , and that death occurred at <u>4:40 P. M.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>L. Allan Gay, M.D.</u>		23b. ADDRESS <u>State Cancer Hospital - Columbia</u>	
(Degree or title) <u>0</u>		23c. DATE SIGNED <u>6 July 1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>6/7/50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Salena</u>		24d. LOCATION (City, town, or county) (State) <u>Mo. Salena</u>	
DATE REC'D BY LOCAL REG. <u>July 7 1950</u>		REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>	
31		25. FUNERAL DIRECTOR'S SIGNATURE <u>Parker Funeral Service</u>	
ADDRESS <u>Columbia Mo.</u>		ADDRESS	

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

RECEIVED 7-10-52
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 7-10-52

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 Thas L. Zaring

Licensed Embalmer No. 4132

P. O. Address Columbia, S.C.

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.