

FILED: DEC 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36711

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 1081		
1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission). a. STATE Missouri b. COUNTY Greene				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield			c. LENGTH OF STAY (In this place) 8 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield 1396			
d. FULL NAME OF HOSPITAL OR INSTITUTION St Johns Hospital				d. STREET ADDRESS (If rural, give location) 1445 Cherry 0				
3. NAME OF DECEASED (Type or Print) a. (First) Herman		b. (Middle) L.		c. (Last) Klann		4. DATE OF DEATH (Month) (Day) (Year) December 5 1950		
5. SEX 0 Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2		8. DATE OF BIRTH Dec 23, 1874	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor Sander		10b. KIND OF BUSINESS OR INDUSTRY Floor Sanding		11. BIRTHPLACE (State or foreign country) Wisconsin /		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME August Klann			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE -----		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ralph A Klann, Springfield, Missouri				
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastric Obstruction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma stomach recurrent DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 157X					INTERVAL BETWEEN ONSET AND DEATH 4 wks 1 yr	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Carcinoma Stomach				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) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from Jan, 1950, to Dec 5, 1950, that I last saw the deceased alive on Dec 4, 1950, and that death occurred at 5:20A m., from the causes and on the date stated above.								
23a. SIGNATURE R. D. Duncan (Degree or title) M.D.				23b. ADDRESS Springfield, Mo		23c. DATE SIGNED 12-5-50		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 0		24b. DATE Dec 7, 1950		24c. NAME OF CEMETERY OR CREMATORY Eastlawn Cemetery		24d. LOCATION (City, town, or county) (State) Springfield, Missouri		
DATE REC'D BY LOCAL REG. 12-5-50		REGISTRAR'S SIGNATURE W E Handley M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alma Schmeyer, Springfield, Mo				

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

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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.....

Bernard J. Wright

Licensed Embalmer No. *4293*

P. O. Address.....

Springfield

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.