

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34247

State File No.

FILED NOV 15 1951

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BIRTH NO. _____ REG. DIST. NO. 178 PRIMARY REG. DIST. NO. 4282 Registrar's No. 93

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>LEWIS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LEWIS</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MONTICELLO</u> | | c. LENGTH OF STAY (In this place) <u>6 mos.</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>XXXXX</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CANTON, MO.</u> <u>0560</u> | |
| | | d. STREET ADDRESS (If rural, give location) <u>XXXXX</u> <u>0</u> | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>ELIZABETH</u> b. (Middle) _____ c. (Last) <u>KLING</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>NOV.</u> <u>8</u> <u>1951</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>MARCH 20, 1864</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>XXXXXXX</u> | 9. AGE (In years last birthday) <u>87</u> if UNDER 1 YEAR <u>7</u> Days if UNDER 12 HRS. <u>18</u> Min. |
| 11. BIRTHPLACE (State or foreign country) <u>BLAKESBURG, IOWA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13a. FATHER'S NAME <u>JOHN KIELKOPF</u> | | 13b. MOTHER'S MAIDEN NAME <u>CATHERINE RITTER</u> | 14. NAME OF HUSBAND OR WIFE <u>P. J. KLING</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> <u>XXXXXX</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>MRS. SELBY SIMPSON</u> ADDRESS <u>CANTON, MO.</u> |
| 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) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</u> 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 <u>332X</u> | 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 <u>April 5, 1949</u> , to <u>Nov 8, 1951</u> , that I last saw the deceased alive on <u>Nov 5, 1951</u> , and that death occurred at <u>4pm</u> m., from the causes and on the date stated above. | | | |
| 23a. SIGNATURE (Degree or title) <u>Charles W. Arnold M.D.</u> | | 23b. ADDRESS <u>Canton Mo.</u> | 23c. DATE SIGNED <u>Nov 10-51.</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>11/12/51</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>MCCORMICK</u> | 24d. LOCATION (City, town, or county) (State) <u>OTTUMWA IOWA</u> |
| DATE REC'D BY LOCAL REG. <u>11/10/51</u> | REGISTRAR'S SIGNATURE. <u>P. W. Jennings</u> <u>161</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Arnold</u> ADDRESS <u>Leawards, Mo.</u> | |

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

Date Received: **NOV 13 1951**
DISTRICT HEALTH OFFICE #2
District File Number *11-57-2003*
Date Filed: **NOV 13 1951**

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

Charles L. Conroy, Jr.

Licensed Embalmer No. 4667

P. O. Address LEWISTOWN, 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.