

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18539**

FILED JUN 1 - 1953

BIRTH NO. _____ REG. DIST. NO. 169 PRIMARY REG. DIST. NO. 5612 Registrar's No. 42

1. PLACE OF DEATH a. COUNTY Knox		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Knox	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 6 Mi. So Knox City		c. LENGTH OF STAY (In this place) life	
d. FULL NAME OF HOSPITAL OR INSTITUTION Residence		d. STREET ADDRESS (If rural, give location) 0520	

3. NAME OF DECEASED (Type or Print) Mary Lucinda Klocke			4. DATE OF DEATH (Month) (Day) (Year) May 17, 1953		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED married	8. DATE OF BIRTH June 23, 1893	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Nebraska	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Finley S. Myers	13b. MOTHER'S MAIDEN NAME Emma Baker	14. NAME OF HUSBAND OR WIFE Franklin William Klocke
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Frank Klocke
		ADDRESS Knox City, 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Myeloma ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH 1 year
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 203X	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)	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 Sept 1952 to May 17, 1953, that I last saw the deceased alive on May 16, 1953 and that death occurred at 5:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE Waldo R. Jones M.D.	23b. ADDRESS Knox City Mo	23c. DATE SIGNED 5/18/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 19, 1953	24c. NAME OF CEMETERY OR CREMATORY Bee Ridge Cemetary
		24d. LOCATION (City, town, or county) (State) Knox County, Mo

DATE REC'D BY LOCAL REG. May 20-53	REGISTRAR'S SIGNATURE Helle S. Hummel	25. FUNERAL DIRECTOR'S SIGNATURE Edimer Edina, Mo
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(Licensed Embalmer's Statement on Reverse Side)

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~~

Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed

Mrs J. W. Hudson

Licensed Embalmer No.

2972

P. O. Address

Edina 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.