

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32401**

FILED OCT 9 - 1953

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **338**

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| 1. PLACE OF DEATH a. COUNTY MARION | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE CALIFORNIA b. COUNTY LOS ANGELES | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HANNIBAL | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN LOS ANGELES 9040 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 2827 MARKET ST. | | d. STREET ADDRESS (If rural, give location) 2019 WEST EIGHTH PLACE | |

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|-------------------------------------|-------------------------|-------------|-------------------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) ALICE | b. (Middle) | c. (Last) KLEVER | 4. DATE OF DEATH (Month) (Day) (Year) |
| | | | | 9-26-53 |

| | | | | | | | | |
|----------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|-----------------------|----------------------|
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED | 8. DATE OF BIRTH DEC. 22, 1879 | 9. AGE (In years) (Last birthday) 73 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 YEAR Hours | IF UNDER 1 YEAR Min. |
|----------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|-----------------------|----------------------|

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|---|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME | 10b. KIND OF BUSINESS OR INDUSTRY HOME | 11. BIRTHPLACE (State or foreign country) HANNIBAL, MISSOURI | 12. CITIZEN OF WHAT COUNTRY? U.S. |
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| | | |
|---|--|-----------------------------|
| 13a. FATHER'S NAME CHARLES A. KLEVER | 13b. MOTHER'S MAIDEN NAME PAULINA GARNETT | 14. NAME OF HUSBAND OR WIFE |
|---|--|-----------------------------|

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|--|-------------------------|--|---------|
| 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 FRANK KLEVER, Hannibal, Mo. | ADDRESS |
|--|-------------------------|--|---------|

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| 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 | | INTERVAL BETWEEN ONSET AND DEATH 5 mos |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of colon | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | 153X | |

| | | |
|---------------------------------------|---|--|
| 19a. DATE OF OPERATION 6-14-53 | 19b. MAJOR FINDINGS OF OPERATION Operated at Mercy Hospital Mason City, Iowa | 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

| | | |
|---|-----------------------------------|------------------|
| 23a. SIGNATURE E. M. Lucke, M.D. (Degree or title) | 23b. ADDRESS Hannibal, Mo. | 23c. DATE SIGNED |
|---|-----------------------------------|------------------|

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|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24b. DATE 9-29-53 | 24c. NAME OF CEMETERY OR CREMATORY HYDESBURG CEMETERY | 24d. LOCATION (City, town, or county) (State) MARION Co., MISSOURI |
|---|--------------------------|--|---|

| | | | |
|---|--|--|------------------------------|
| DATE REC'D BY LOCAL REG. 9-28-53 | REGISTRAR'S SIGNATURE E. M. Lucke | 25. FUNERAL DIRECTOR'S SIGNATURE Jack Scherwitz | ADDRESS Hannibal, Mo. |
|---|--|--|------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

OCT 8 1953

RECEIVED

MARION CO. HEALTH DEPT.

DATE FILED OCT 8 1953

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

Jack Schwartz

Licensed Embalmer No. *84900*

P. O. Address *Hannibal, 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.