

FILED FEB 4 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **850**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **116** PRIMARY REG. DIST. NO. **3020** Registrar's No. **66**

1. PLACE OF DEATH a. COUNTY <b>Franklin</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Franklin</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Washington</b>		c. CITY OR TOWN <b>Washington</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>68 yrs</b>		e. STREET ADDRESS (If rural, give location) <b>307 Oak St. 0360</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>307 Oak St.</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Martha</b> b. (Middle) <b>Mathilda</b> c. (Last) <b>Klingsick</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Jan 26 1957</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	
8. DATE OF BIRTH <b>Dec 10-1888</b>		9. AGE (In years last birthday) <b>68</b>		10. IF UNDER 1 YEAR: Months <b>1</b> Days <b>16</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Washington, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Charles Klingsick</b>		13b. MOTHER'S MAIDEN NAME <b>Olivia Detweiler</b>	
14. NAME OF HUSBAND OR WIFE <b>None</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>491-16-4114A</b>	

17. INFORMANT'S SIGNATURE OR NAME <b>Amanda Klingsick</b>		ADDRESS <b>Washington, Mo</b>	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute cardiac decompensation</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chr Myocarditis</b>		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		20. AUTOPSY? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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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?	
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22. I hereby certify that I attended the deceased from **Sept 20 1914** to **Jan 26, 1957** that I last saw the deceased alive on **Jan 26, 1957**, and that death occurred at **4:00 pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>Ms</b>		23b. ADDRESS <b>Washington Mo</b>		23c. DATE SIGNED <b>1/28/57</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Jan 29, 1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Lutheran Cemetery, Washington Mo</b>	
24d. LOCATION (City, town, or county) (State) <b>Washington Mo</b>		DATE REC'D BY LOCAL REG. <b>1/29/57</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	

25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>Nieburg &amp; Vitt Inc, Washington, Mo</b>	
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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.....  
Signature of Student Embalmer

Signed *Jerome F. Swoboda*.....

Licensed Embalmer No. *450*

P. O. Address *Washington*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.