

FILED DEC 5 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40435
STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5479

S. 300
ev. 1-57

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osteopathic Hospital | | Length of stay 2 Weeks | d. STREET ADDRESS 2040 Lawn Avenue | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Hazel Middle Bertha Last Kloiber | | | 4. DATE OF DEATH Month November Day 20 Year 1957 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 6, 1892 | 9. AGE (In years last birthday) 75-3-24 | IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Kansas City, Kansas | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13a. FATHER'S NAME Charles Layton | | 13b. MOTHER'S MAIDEN NAME Anna Harris | | 14. NAME OF HUSBAND OR WIFE Charles Anthony Kloiber | |
| 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. 510-05-6216 | | 17. INFORMANT Mrs. Irene Cain, 2040 Lawn, K.C. Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock due to Pulmonary Embolism Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardial Decompensation = Stasis DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cor Pulmonale | | | | | INTERVAL BETWEEN ONSET AND DEATH 4221 |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | |
| 20c. TIME OF INJURY Hour 1:03 Month Nov Day 20 Year 1957 a.m. AM p.m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from Nov. 1-1957 to Nov. 20-1957 and last saw her alive on Nov. 19-1957 Death occurred at 1:03 AM m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE M.C. Coatney DO <small>(In course or title)</small> M.C. Coatney DO | | | 22b. ADDRESS 6235 Truman Road, K.C. Mo. | | 22c. DATE SIGNED 11/20/57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE Nov. 25-1957 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery | | 23d. LOCATION (City, town, or county) (State) Kansas City, Kansas | |
| 24. FUNERAL DIRECTOR Jos. A. Butler's Sons, Kansas City, Kas | | 25. DATE RECD. BY LOCAL REG. 11-20-57 | 26. REGISTRAR'S SIGNATURE Irva Minshall | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

KP
2

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 _____
[Handwritten Signature]

Licensed Embalmer No. 3426 Mo.
P. O. Address Kansas City, Kansas

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.