

FILED MAR 31 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008815

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 145

1. PLACE OF DEATH a. COUNTY <b>Boone</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, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Washington</b> <sup>036 2</sup>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>University Medical Center</b>		Length of stay in 1b <b>10 days</b>	d. STREET ADDRESS (If outside, give location) <b>105 E 3rd</b>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>John</b> Last <b>Klingsick</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>28</b> Year <b>1958</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/5/05</b>		9. AGE (In years last birthday) <b>52</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) <b>Shoe Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Factory</b>	11. BIRTHPLACE (City and state or country) <b>Washington, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>

13a. FATHER'S NAME <b>Charles Klingsick</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA Meyer</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>491-26-3325</b>		17. INFORMANT Address <b>Patents Hospital Record</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertensive Cardiovascular disease</b>		<b>2 years.</b>
	DUE TO (c) <b>Chronic Glomerulonephritis</b>		<b>2 years?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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.) <b>i</b>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 **3/18/58** to **3/28/58** and last saw her/him alive on **3/28/58**  
Death occurred at **305 P** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Of free or title) <b>Dale B. Sparks M.D.</b>	22b. ADDRESS <b>Columbia, Mo. University Hospital</b>	22c. DATE SIGNED <b>3/28/58</b>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>3/31/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran</b>	23d. LOCATION (City, town, or county) (State) <b>Washington Mo.</b>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <b>Henry W. Otto</b>	ADDRESS <b>Washington Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>March 28 1958</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>
--	----------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Health, Welfare, Public Service

300  
-57  
0

APR 4 1958

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 Henry W. Otts .....

Licensed Embalmer No. 3560 .....

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.