

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044215

STATE FILE NUMBER

FILED JAN 9 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6077

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 St. Joseph Hosp.			Length of stay in lb. 10 years		d. STREET ADDRESS (If outside, give location) 207 Garfield		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOHN Middle Bryant Last KLOTZ				4. DATE OF DEATH Month Dec. Day 19, Year 1958					
5. SEX Male	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 Jan. 26, 1899		9. AGE (In years last birthday) 59	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor			10b. KIND OF BUSINESS OR INDUSTRY Fiber-glass Co. Guston Bacon		11. BIRTHPLACE (City and state or country) Orrick, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Marshall Klotz				14. MOTHER'S MAIDEN NAME Ida Hendricks Klotz Swigart					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes World War I		16. SOCIAL SECURITY NO. 490-09-2804		17. INFORMANT Mrs. John Swigart Wellington, 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) Cerebral Embolism							INTERVAL BETWEEN ONSET AND DEATH 6 days		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardial Degeneration							2 years		
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4222							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2		
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 Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <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 4/1/58 to 12/19/58 and last saw her alive on 12/19/58 Death occurred at 10:30 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Arthur B. Rhoades M.D.				22b. ADDRESS 630 Professional Bldg. Cr.			22c. DATE SIGNED 12/20/58		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)				
Burial		Dec. 21, 1958	Buckner Cemetery		Buckner Missouri				
24. FUNERAL DIRECTOR J. C. Sheppard Wellington, Missouri				25. DATE RECD. BY LOCAL REG. 12-23-58		26. REGISTRAR'S SIGNATURE Neva Marshall			

Health, Welfare Public Service

300 1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Arthur B. Rhoades

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 *J. Blair Sheppard*

Licensed Embalmer No. *41*

P. O. Address *Wellington*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.