

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-011730

FILED VS APR 4 1960

Registration District No. 167 Primary Registration District No. 3040 Registrar's No. 57

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in lb <u>8 mo.</u>		c. CITY OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>423 Clay St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>225 Tenth</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Klein</u> Last <u>Klein</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>28</u> Year <u>1960</u>									
5. SEX <u>Fem</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5/23/69</u>		9. AGE (last birthday) <u>90</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Diatrician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (City and state or country) <u>Biedigen, Germany</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>John Klein</u>				13b. MOTHER'S MAIDEN NAME <u>Unknown</u>				14. NAME OF HUSBAND OR WIFE <u>XX</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Anna Klein, Chillicothe, Mo.</u> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis with congestive failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown										INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)									
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u> <u> </u> <u> </u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>July 1-56</u> to <u>3-28-60</u> and last saw her <u>alive</u> on <u>1-4-60</u> Death occurred at <u>10:45 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Joseph F. Gale MD</u>						22b. ADDRESS <u>Chillicothe Mo</u>			22c. DATE SIGNED <u>3-29-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>3/30/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Catholic cemetery</u>			23d. LOCATION (City, town, or county) <u>Chillicothe Mo.</u>			(State)			
24. FUNERAL DIRECTOR <u>Donald Gordon, Chillicothe, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>3-29-60</u>		26. REGISTRAR'S SIGNATURE <u>Frances B Nail</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard W. Bando

Licensed Embalmer No. 4866

P. O. Address Chillicothe

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.