

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-043125

FILED VS DEC 7 1960 290

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. Registrar's No. 153

1. PLACE OF DEATH a. COUNTY Pulaski				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ft. Leonard Wood, Mo.		Length of stay in 1b		c. CITY OR TOWN Ft. Leonard Wood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) US Army Hospital		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM KLOEPPEL				4. DATE OF DEATH Month Day Year November 17, 1960					
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Nov 17, 60	9. AGE (last birthday) IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Mjn. 2 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Ft Leonard Wood, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME LEO FRANK KLOEPPEL			13b. MOTHER'S MAIDEN NAME ANGELINE VIRGINIA JACOBS			14. NAME OF HUSBAND OR WIFE -			
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. -		17. INFORMANT Address Leo F. Kloepfel, Fort Leonard Wood, 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) Respiratory Insufficiency							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Prematurity		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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			
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 a.m. p.m. Month, Day, Year									
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 November 17, 1960 to November 17, 1960 and last saw him alive on November 17, 1960 Death occurred at 5:03 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) MANUEL J. VARGAS, Captain, MC				22b. ADDRESS US Army Hospital Fort Leonard Wood, Missouri				22c. DATE SIGNED Nov 18, 60	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-21-60	23c. NAME OF CEMETERY OR CREMATORY Post Cemetery			23d. LOCATION (City, town, or county) (State) Ft. Leonard Wood, Mo				
24. FUNERAL DIRECTOR Marie's Funeral Home			ADDRESS 11-21-60		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE Paula Mae Anderson		

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 Clarence Moss

Licensed Embalmer No. 4896

P. O. Address Waynesville,

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.