

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-030376

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 94

FILED SEP 11 1962

VS 300
Rev. 4/59

6001
28120

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90021

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127-0

131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBON

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Christian</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs, Mo.</u>		Length of stay in 1b <u>120 days</u>	c. CITY OR TOWN <u>Mount Auburn</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Veterans Administration INSTITUTION <u>Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>- - - -</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE ROBERT KLEIBER</u>		4. DATE OF DEATH Month Day Year <u>August 23, 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-19-17</u>
9. AGE (last birthday) <u>44</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Production Control</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	11. BIRTHPLACE (City and state or country) <u>Pekin, Illinois</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Kleiber</u>	
13b. MOTHER'S MAIDEN NAME <u>Ollie Merrit</u>		14. NAME OF HUSBAND OR WIFE <u>- - - -</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>John F. Kleiber, brother, 25804 E. Walker San Bernardino, California</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis, pulmonary, far advanced, active, caused by unclassified mycobacteria, photochromogenic (Group I)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 yrs.</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)	
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 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.)	
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. <input checked="" type="checkbox"/> attended the deceased from <u>April 25, 1962</u> to <u>August 23, 1962</u> Death occurred at <u>6:00 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. T. O'Kell</u> (Degree or title) <u>R. T. O'KELL, M.D., Pathologist</u>		22b. ADDRESS <u>St. Lukes Hospital, Kansas City, Mo</u>	22c. DATE SIGNED <u>8-23-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-23-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>- - - -</u>	23d. LOCATION (City, town, or county) (State) <u>Mt. Auburn, Illinois</u>
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Ex. Springs, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-23-62</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>

SEP 20 1962

SEP 12 1962

Removal permit issued 8/23/62. B.N.

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 Ralph Van Landingham

Licensed Embalmer No. 4099

F. O. Address Gelesic Springs, Mo.

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.