

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-016891

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 236 Primary Registration District No. 5816 Registrar's No. 34

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 30 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>MORGAN</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RICKLAND TWP</u> Length of stay in 1b <u>27 YRS.</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VERSAILLES MO.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission)</p> <p>a. STATE <u>MISSOURI</u> b. COUNTY <u>MORGAN</u></p> <p>c. CITY OR TOWN <u>RICKLAND TWP.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>VERSAILLES MO.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>JOHANNA</u> Middle <u>MARIE</u> Last <u>KLEIN</u></p> <p>4. DATE OF DEATH Month <u>APRIL</u> Day <u>24</u> Year <u>1963</u></p>	<p>5. SEX <u>FEMALE</u></p> <p>6. COLOR OR RACE <u>WHITE</u></p> <p>7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>FEB. 24 1936</u></p> <p>9. AGE (last birthday) Months <u>27</u> Days <u></u> Hours <u></u> Min. <u></u></p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u></p> <p>11. BIRTHPLACE (City and state or country) <u>VERSAILLES MO. U.S.A.</u></p> <p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>	<p>13a. FATHER'S NAME <u>JOHNNIE KLEIN</u></p> <p>13b. MOTHER'S MAIDEN NAME <u>AMELIA WINDLER</u></p> <p>14. NAME OF HUSBAND OR WIFE <u>NEVER MARRIED</u></p>
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u></p> <p>16. SOCIAL SECURITY NO. <u></u></p> <p>17. INFORMANT <u>JOHANNE KLEIN</u> Address <u>VERSAILLES MO.</u></p>	<p>18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u>Epilepsy</u></p> <p>DUE TO (c) <u></u></p> <p style="text-align: right;">INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS</u> <u>27 YRS.</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u></u></p> <p>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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u></u></p>	<p>20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u></p>
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u></p> <p>20f. CITY, TOWN, OR LOCATION <u></u> COUNTY <u></u> STATE <u></u></p>	<p>21. I attended the deceased from <u>1950</u> to <u>April 24 1963</u> and last saw her alive on <u>April 24 1963</u>. Death occurred at <u>8:30 P.M.</u> of the date stated above, and to the best of my knowledge, from the causes stated.</p>
<p>22a. SIGNATURE <u>Jack Gunn MD</u> (Degree or title)</p> <p>22b. ADDRESS <u>Versailles, Mo.</u></p> <p>22c. DATE SIGNED <u>4/26/63</u></p>	<p>23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u></p> <p>23b. DATE <u>APRIL 28 1963</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>FLORENCE CEMETERY</u></p> <p>23d. LOCATION (City, town, or county) (State) <u>FLORENCE MO.</u></p>
<p>24. FUNERAL DIRECTOR <u>Samuel Steiner</u> Address <u>Mo.</u></p> <p>25. DATE RECD. BY LOCAL REG. <u>4-27-63</u></p> <p>26. REGISTRAR'S SIGNATURE <u>J. Washburn</u></p>	<p>27. <u></u></p>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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USE BLACK INK OR TYPEWRITER RIBBON

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. L. Stevenson

Licensed Embalmer No. 4073

P. O. Address Stoner Me.

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.