N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17640

JUN 17 1940

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 2167

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1104 Oak St. 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 4 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 916 Oak
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Herman H. Fleer 460

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Minnie D. Fleer

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased December 19, 1873
(Month) (Day) (Year)

8. AGE: Years 66 Months 5 Days 6 If less than one day ..... hr. ..... min.

9. Birthplace Quincy (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Manager of

11. Industry or business Rug Cleaning Co.

FATHER
12. Name Peter Fleer 6
13. Birthplace ..... (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Annie Eickemeyer 6
15. Birthplace ..... (City, town, or county) Germany (State or foreign country)

16. (a) Informant's own signature Drehmann-Harral Co.
(b) Address St. Louis, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-27-1940 (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis, Missouri

18. (a) Signature of funeral director J. F. O'Donnell
(b) Address # 3256 Broadway, K. C. Mo.

19. (a) May 27, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25
year 1940 hour 11 minute 40 P. M.

21. I hereby certify that I attended the deceased from ..... to ..... 19....;
that I last saw ..... alive on ..... 19....;
and that death occurred on the date and hour stated above.

Deputy Coroner

Immediate cause of death — Duration
Acute pulmonary congestion
Due to Hypertrophy of the heart
Due to Chronic myocardial infarction
Due to Old & recent coronary occlusion

Other conditions
(Include pregnancy within 3 months of death)

95 P.M.

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury 5

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23. Signature Victor M. Fuhler (M. D. or other)
Address K. C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Park G. Rowe

Licensed Embalmer No. 2347

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.