

S. No. 2
M-9-4-41
5-17-39
X29484

18289

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUN 11 1943

Registration District No. 4289

Primary Registration District No. 4289

Registrar's No.

1. PLACE OF DEATH:

(a) County Lincoln

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

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify number)

In this community In this community (Specify number)
years, months or days 29

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHN KLIEVER

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased June 17 1859
(Month) (Day) (Year)

8. AGE: Years 83 Months 9 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Blacksmith

11. Industry or business _____

12. Name John Kleiver

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Ed Kliever

(b) Address Hawkpoint Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14 43
(Month) (Day) (Year)

(c) Place: burial or cremation Hawkpoint Cem.

18. (a) Signature of funeral director Walter Mc Coy

(b) Address Troy Mo.

19. (a) May 8 - 43 (Date received local registrar) Mrs. Floy Gaskin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12th
year 1943 hour 6 minute A.M.

21. I hereby certify that I attended the deceased from Feb., 1940, to April 12th, 1943
that I last saw him alive on April 12th, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 92d

Duration

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)

23. Signature V.C. Althoff (M.D. or other) 80.
Address Troy, Mo. Date signed 4/15/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

118P

(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.....

Wayne McLoay

Licensed Embalmer No.....

3585

P. O. Address.....

Jroy 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 this body is not embalmed, fact should be so stated above.