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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 23 1945

32597

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4211

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: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community Unknown 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. 318½ E. 12th St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Clondt, Henry
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Unknown
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May 10, 1877 (Month) (Day) (Year)

8. AGE: Years 68 Months 4 Days 13 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) (State or foreign country)
10. Usual occupation Unknown
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Record Clerk
(b) Address General Hospital No. 1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-45 (Month) (Day) (Year)
(c) Place: burial or cremation Leeds
18. (a) Signature of funeral director Wm A Lohmeyer
(b) Address City Mortician
19. (a) 10-13-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 23 year 1945 hour 4 minute 30 P M.
21. I hereby certify that I attended the deceased from September 21, 1945, to September 23, 1945; that I last saw him alive on September 23, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death cardiac decompensation

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

Duration

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

23. Signature Clark W Seely (M. D. or other)
Address Med. Dir. K. C. General Hospital Date signed 10-1-45

(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 Not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed Wm. A. Lohmeyer

Licensed Embalmer No. 3084

P. O. Address 15 C 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.