

No. 2  
12-45  
17-39  
K47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

87773

FILED MAR 20 1948

State File No. \_\_\_\_\_

Registration District No. 949

Primary Registration District No. 1002

Registrar's No. 1071

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

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 St. Lukes  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 weeks  
(Specify whether  
In this community 2 weeks  
years, months or days)

3. (a) PRINT FULL NAME

Herman Kinop (KNOB)

3. (b) If veteran, name war no

3. (c) Social Security No. 509-12-4032

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Settie

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

7. Birth date of deceased September 10, 1867  
(Month) (Day) (Year)

8. AGE:

Years 80 Months 5 Days 28 hr. \_\_\_\_\_ min.

9. Birthplace

Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

12. Name

unknown 9

13. Birthplace

unknown 9

14. Maiden name

15. Birthplace

unknown 9

16. (a) Informant

MRS. L. L. KINOP

(b) Address

1111 S. Washington

17. (a) Removal

Removal (b) Date thereof 3-8-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

Cluthe, Kansas

18. (a) Signature of funeral director

Martin W. Frye

(b) Address

Cluthe, Kansas

19. (a) 3-9-48

(b) Sheraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Jackson 999  
(c) City or town Cluthe 14  
(If outside city or town limits, write "RURAL")  
(d) Street No. S. Walnut St. 0  
(If rural, give location)  
(e) Citizen of foreign country? unknown 3  
(Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 8th day  
year 1948-7 hour 03 PM minute \_\_\_\_\_ M.

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

Immediate cause of death Heart failure  
Confluent broncho pneumonia

Duration

Due to Coronary sclerosis

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:

Of operations \_\_\_\_\_  
Of autopsy Consolidation of bronchopneumonia 93d

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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? \_\_\_\_\_

23. Signature Paul J. Preston (M. D. or other) \_\_\_\_\_  
Address St. Lukes Hosp Date signed 3-8-48

MAR 26 1951

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.....

*Martin W. Frye*

Registered Apprentice No.

working under my personal supervision.

Signed:

*Martin W. Frye*

Licensed Embalmer No. *3615*

P. O. Address. *Ala. Hwy, Kause*

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.