Health, Welfare Public Service

300 4 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-013121
STATE FILE NUMBER

FILED MAY 14 1958

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 98

1. PLACE OF DEATH a. COUNTY Audrain	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cole 0264
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mexico, Mo. Inside Limits Yes ☒ No ☐	c. CITY OR TOWN Jefferson City Mo. Inside Limits 0 Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Allen Nursing Home Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 703 Deleware Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: JOHN	Middle: JOSEPH	Last: KLOEPPEL	4. DATE OF DEATH Month, Day, Year: APRIL 26, 1958				
5. SEX: Male 0	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ 0 DIVORCED ☐	8. DATE OF BIRTH: Dec. 8, 1880	9. AGE (In years last birthday): 77	IF UNDER 1 YEAR Months: 4 Days: 18	IF UNDER 24 HRS. Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lumberman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Linn, Mo. 0	12. CITIZEN OF WHAT COUNTRY? USA				
13a. FATHER'S NAME: William Kloeppel	13b. MOTHER'S MAIDEN NAME: Elizabeth Flanagan	14. NAME OF HUSBAND OR WIFE: None					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: William Bret	Address: J C Mo.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3½ weeks

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis — yrs

DUE TO (c): 332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4-21-58 to 4-26-58 and last saw ~~him~~ him alive on 4-23-58

Death occurred at 2 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): W. McCullough MD 0	22b. ADDRESS: Mexico, Mo.	22c. DATE SIGNED: 5-3-58	
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4/28/58	23c. NAME OF CEMETERY OR CREMATORY: St. Peters	23d. LOCATION (City, town, or county) (State): Jefferson City, Mo.
24. FUNERAL DIRECTOR: Sylvester Quelle	ADDRESS: J C Mo.	25. DATE RECD. BY LOCAL REG.: May 7-1958	26. REGISTRAR'S SIGNATURE: Blanche Neely

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Sylvester Dodd

Licensed Embalmer No. 4321

P. O. Address Jefferson Ct.

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.