

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

11888

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 1819
 Township Kaw City Primary Registration District No. 1002 Registered No. 1819
 City Kansas City (No. 3428) Virginia St. _____ Ward _____

2. FULL NAME

William Pritz
 (a) Residence. No. 3428 Virginia St., _____ Ward. _____
 (Usual place of abode) _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 13 - 1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
80 9 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Germany
 (STATE OR COUNTRY) _____

10. NAME OF FATHER Jacob Pritz

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Lydia Pritz

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY) _____

14. INFORMANT Wm. J. Robinson
 (Address) 3428 Virginia K.C. Mo.

15. FILED 4/23, 1925 M. M. Leavine
 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) April 23 1925

17. I HEREBY CERTIFY That I attended deceased from April 12 1925 to April 22 1925 that I last saw him alive on April 20 1925, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis associated with high blood pressure
 (duration) 2 yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) Cystitis
 (duration) _____ yrs. _____ mos. 10 da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH: _____ at place of death

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination
 (Signed) Edw. Gehring M.D.
23, 1925 (Address) 303 Skuller Blvd

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cemetery DATE OF BURIAL 4-24 1925

20. UNDERTAKER John J. Theisen ADDRESS K.C. Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

