

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

Do not use this space.

✓ 5066

1. PLACE OF DEATH

County Jackson
Township Can
City W.C.

Registration District No. 399
Primary Registration District No. 1002
(No. 2911 Garbor)

File No. _____
Registered No. 866
St. _____ Ward _____

2. FULL NAME

Joseph F. Kasberger
(a) Residence No. 2911 Garbor St. Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

Chief

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 24, 1926

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
3 4

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Joseph Kasberger

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

12. MAIDEN NAME OF MOTHER Elyzabeth Rubryer

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

14. INFORMANT Joseph Kasberger
(Address) 2911 Garbor

15. FILED 28-27 W. M. Crowe
19 28 REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 1927

17. I HEREBY CERTIFY, That I attended deceased from February 18, 1927 to February 28, 1927, that I last saw him alive on Feb 28, 1927, and that death occurred, on the date stated above, at 11:33 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Erysipelas of Face & Trunk.
15B
11913

(duration) yrs. mos. 10 da. 10 da.
CONTRIBUTORY Geo-Colitis (acute)
(SECONDARY)
(duration) yrs. mos. 10 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: 2911 Garbor

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

20. WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS Symptoms only
(Signed) F. J. Siemann, M. D.

Feb. 28, 1927 (Address) 3336 Summit St.

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Interment Society DATE OF BURIAL March 1 1927

20. UNDERTAKER John A. Muser ADDRESS 1415 215

THIS IS A PERMANENT RECORD. 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.

SECRET
U.S. GOVERNMENT PRINTING OFFICE: 1964

FROM: [illegible]

TO: [illegible]

DATE: [illegible]

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 399
Primary Registration District No. 1002

File No.....
Registered No. 866
St. Ward)

2. FULL NAME

(a) Residence No. 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 mt 4. COLOR OR RACE wt 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 128 27 19 27 M. M. Grove REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 28 1927

17. I HEREBY CERTIFY, That I attended deceased from to 19....., and that I last saw him..... alive on..... 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

ruptures of face and neck (Idiopathic)
fractured under left ear with no visible trauma (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Herpes zoster, acute (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)....., M. D.
, 19 (Address)

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

RECORD WITH THIS IS A PERM... THIS IS A PERM... THIS IS A PERM...

could be stated EXACTLY. Exact statement of O.

ly sup... be pro...

3.—Every item of info... SE OF DEATH in pla

UNTIL THEY ARE COMPLETE AS PRESCRIBED B. LA'V
OR CERTIFICATES
REGISTRARS SHALL NOT RL

SUPPLEMENTARY

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(10.11.19)