

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

28 06 Jefferson 11 30
 Do not use this space.
32045
 File No. _____
 Registered No. **9306**
 St. _____ Ward _____

1. PLACE OF DEATH

County..... Registration District No. **7811**
 Township..... Primary Registration District No. **1003**
 City **Spheria Mo.** (No. **5330**) **Blow**

2. FULL NAME

George J. Kissell
 (a) Residence. No. **5330** **Blow** St., **2** 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 **Magdalena Kissell**
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Mar 13 - 1863**
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hra. ormin.
65 | 6 | 3

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Clerk.**
 (b) General nature of industry, business, or establishment in which employed (or employer) **Dry Goods.**
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) **Spheria**
 (STATE OR COUNTRY) **Mo**

10. NAME OF FATHER **John Kissell**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Spheria**
 (STATE OR COUNTRY) **Mo**
 12. MAIDEN NAME OF MOTHER **Unknown Baer**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Spheria**
 (STATE OR COUNTRY) **Mo**

14. INFORMANT **Magdalena Kissell**
 (Address) **5330 Blow St Louis Mo**

15. FILED **SEP 18 1928** **W. C. Stankler**
 19. _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 16 1928**
 17. I HEREBY CERTIFY, That I attended deceased from **9-7**, 19**28**, to **9-16**, 19**28**, that I last saw h. **in** alive on **9-15**, 19**28**, and that death occurred, on the date stated above, at **8:00 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93 V

CONTRIBUTORY (SECONDARY) **9016**
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? **Unknown**
 DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____
 WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **Julius E. Kelly**, M. D.
9/17, 19**28** (Address) **2532 S Jefferson**

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **S.S. Peter + Paul** DATE OF BURIAL **9-19 1928**

20. UNDERTAKER **Weick Bros 2201 So Grand**
 ADDRESS _____

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.

