

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.

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

Do not use this space.

1786

1. PLACE OF DEATH

County..... **Jackson**  
Township..... **Kaw**  
City..... **Kansas City**

Registration District No. .... **899**  
Primary Registration District No. .... **1002**  
(No. **8111 Independence Ave.**)

File No. .... **570**  
Registered No. .... **570**  
St. .... Ward

2. FULL NAME

**John H. Quistgaard**

(a) Residence. No. .... **8111 Independence Ave.** Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred **47** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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

**Olivia Quistgaard**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Apr. 10, 1854**

7. AGE

**74**

YEARS

MONTHS

**9**

DAYS

**12**

IF LESS than 1 day, .... hrs. or .... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Retired Publisher**

(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)

**Denmark**

10. NAME OF FATHER **A. Wilhelm Quistgaard**

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

**Denmark**

12. MAIDEN NAME OF MOTHER **Catherine Hojar**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

**Denmark**

14.

INFORMANT

**Mrs Olivia Quistgaard**

(Address)

**8111 Independence Ave.**

15.

FILED

**1-25-29**

**M. M. Crow**

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

**Jan 22 19 29**

17.

I HEREBY CERTIFY, That I attended deceased from **Dec 13 1928** to **Jan 22 1929**, and that I last saw him alive on **July 18 1928**, and that death occurred, on the date stated above, at **10 28** m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Myocarditis heart**

CONTRIBUTORY (SECONDARY)

**Diabetes met.**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

**his home**

DID AN OPERATION PRECEDE DEATH

DATE OF

WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

**L. V. Lamb**

\*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

**Forest Hill**

DATE OF BURIAL

**1/25/1929**

20. UNDERTAKER

**W. M. Mortuary**

ADDRESS

**104 W 42**

