

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

Do not use this space.

1161

1. PLACE OF DEATH

County Jackson
Township Haw
City K.C.

Registration District No. 399
Primary Registration District No. 1003
(No. H38 Elmwood)

File No. _____
Registered No. 149
St. _____ Ward _____

2. FULL NAME

Eldon Junior Kreisler

(a) Residence. No. H38 Elmwood 10. Ward.

(If nonresident, give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan. 11, 1930</u>		
7. AGE	YEARS	MONTHS
		DAYS
		IF LESS than 1 day, <u>27</u> hrs. or <u>1</u> min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) K.C.
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Eldon Kreisler

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

12. MAIDEN NAME OF MOTHER Beatrice Eaton

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

14. INFORMANT Eldon Kreisler
(Address) H38 Elmwood

15. FILED Jan 13 30 M. M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 12, 1930

17. I HEREBY CERTIFY That I attended deceased from 1-11-30 to 1-12-30 that I last saw h. alive on 1-11-30 and that death occurred, on the date stated above, at 3:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Patent foramen Ovale
1592 (duration) yrs. mos. ds. 1

CONTRIBUTORY (SECONDARY) none
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? 1592
IF NOT AT PLACE OF DEATH 0
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED clinical findings
(Signed) [Signature] M. D.
(Address) Kansas City Mo

*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 Cole Camp, Mo. DATE OF BURIAL Jan. 13, 1930

20. UNDERTAKER P. H. Blackman ADDRESS 509 282 50th St

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.

