

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

Do not use this space.

NOV 18 1937

36680

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 57)

Registration District No. 399
Primary Registration District No. 1002
St. Joseph Hosp

File No. _____
Registered No. 622
St. _____ Ward)

2. FULL NAME

Louis Phillip Heiser

(a) Residence, No. 4343 Tracy St., Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 35 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 Mrs Celia H. Heiser

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-22-1870

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 11 20

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Traveling Salesman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Yale Paint Co

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Buffalo New York

13. NAME Louis Heiser

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Buffalo New York

15. MAIDEN NAME Carrie Wagner

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Buffalo New York

17. INFORMANT (ADDRESS) Mrs Celia Heister Heiser 4343 Tracy

18. BURIAL, CREMATION, OR REMOVAL PLACE MM Moriah DATE Oct 14 1937

19. UNDERTAKER (ADDRESS) New Men Camers Sons Kansas City Mo.

20. FILED Oct 13 1937 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-12 1937

22. I HEREBY CERTIFY, That I attended deceased from 10-10 1937 to 10-12 1937

I last saw him alive on 10-12 1937 Death is said to have occurred on the date stated above, at 8:45 am

The principal cause of death and related causes of importance were as follows:

Chronic Schistosomiasis
Hypostatic pneumonia
93

Other contributory causes of importance:
Acute bronchitis
chronic myocarditis (hypertension)

Name of operation _____ Date of _____
What test confirmed diagnosis? post Was there an autopsy yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) P. C. Morgan, M. D.

(Address) 110 Professional
16-11-37

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.

5. 2

1910-1911

1912-1913

1914-1915

**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 Jackson
Township St. Joseph
City Kansas City

Registration District No. 399
Primary Registration District No. 11002
No. St. Joseph Hospital

File No. 36680
Registered No. 4109
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 4343 Tracy St., _____ 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 M 4. COLOR OR RACE W 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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
66

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. UNDERTAKER (ADDRESS)

20. FILED 10/13 1937 M. M. Cronin Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 12 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said

to have occurred on the day stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Chronic Atherosclerosis
Arteriosclerosis
Hypostatic pneumonia
Other contributory causes of importance:
Acute pericarditis
Chronic Myocarditis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) C. C. Montgomery M. D.
(Address) 710 Prof Bldg - 5th Flr

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-36680