

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

31291

Do not use this space.

REC'D OCT 15 1938

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399

(b) Township Kean Primary Registration District No. 1002

(c) City Kansas City (d) Street No. McCogen Way St.

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

2. PRINT FULL NAME Welle Fuerstenberg 62?

(a) Residence, No. 503 Olive St.  (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

**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 Joseph Fuerstenberg

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan - 13 - 1879

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

64 7 39

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

9. Industry or business in which work was done, as 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) Iowa

13. NAME Wm King

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

15. MAIDEN NAME unmarried

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

17. INFORMANT Records Clerk

(ADDRESS) 17 E. 1st Street

18. BURIAL, CREMATION, OR REMOVAL St. Lawrence Prot 9-14-38

19. FUNERAL DIRECTOR (NAME) Peter J. Kaselitz

(ADDRESS) 536 Campbell St

20. FILED Sept 13, 1938 M. M. Crowe

Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-11 1938

22. I HEREBY CERTIFY, That I attended deceased from 9-11 1938 to 9-11 1938

I last saw h. alive on 9-11 1938. Death is said to have occurred on the date stated above, at 8:50 am

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

Chronic glomerular nephritis; Hypertrophy of the art

Date of onset

Other contributory causes of importance: 1st

Terminal Bronchopneumonia

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ 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. A. De Maria M. D.

(Address) 517 E. 12th 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.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

..... or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**