

REC'D APR 17 1939

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

9477  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County Jackson Registration District No. 395  
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 1083  
 (c) City Kansas City (d) Street No. 3422 Gillam Road St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (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**

350 Louise Kiewitt  
 (a) Residence, No. 3422 Gillam Road 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 <u>FEMALE</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>WIDOWED</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John Kiewitt</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>DEC. 30th 1860</u>		
7. AGE	YEARS <u>78</u>	MONTHS <u>2</u>
	DAYS <u>10</u>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>HOUSEWIFE</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Home</u>	
	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) <u>GERMANY G</u>		
FATHER	13. NAME UNKNOWN <u>GRONKE G</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>GERMANY G</u>	
MOTHER	15. MAIDEN NAME <u>unknown</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
17. INFORMANT <u>Miss Edith Kiewitt</u> (ADDRESS) <u>3422 Gillam Rd. Kansas City Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Joseph Mo.</u> DATE <u>MAR. 10th 1939</u>		
19. FUNERAL DIRECTOR (NAME) <u>FLEEMAN and Son Inc</u> (ADDRESS) <u>1946 Calhoun St. Joseph, Mo</u>		
20. FILED <u>Mar. 10 1939 M. M. Crowe</u> Local Registrar.		

**MEDICAL CERTIFICATE OF DEATH**21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAR. 10th 1939

22. I HEREBY CERTIFY, That I attended deceased from

Feb. 7, 1939, to Mar. 10, 1939I last saw her alive on Mar. 10, 1939. Death is saidto have occurred on the date stated above, at 12:15 P.M.

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

Senile Degeneration

Other contributory causes of importance:

Dislocated hip follows fall that developed Chronic Pneumonia

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? Acc 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) James J. Ferguson, M. D.(Address) 120 Broadway

**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.....

*John E. Rupp*  
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Licensed Embalmer No.....

P. O. Address.....

*St. Joseph*

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No..... Registered No. 1083  
 (c) City..... (d) Street No..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (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 Louise Kiewith

(a) Residence, No. .... 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 ♀ 4. COLOR OR RACE ..... 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) .....

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.

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

FATHER 13. NAME .....

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

MOTHER 15. MAIDEN NAME .....

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

17. INFORMANT (ADDRESS) .....

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE .....

19. FUNERAL DIRECTOR (ADDRESS) .....

20. FILED 3/10 39 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mon 10, 1939

22. I HEREBY CERTIFY, That I attended deceased from .....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at.....m.

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

Senescent Degeneration Date of onset 1860  
Dislocated hip following fall.

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? Accident Date of injury Mon 2, 1939

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

Manner of injury Fall  
 Nature of injury .....

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

If so, specify James J. Ferguson, M. D. (Address) 124 Broadway

SUPPLEMENTARY

S-9477