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.

REC'D MAY 16 1939

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

15105
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson 3 Registration District No. 400
(b) Township Prairie 1 Primary Registration District No. 5553B Registered No. 104
or
(c) City Little Blue (d) Street No. Jackson County Home 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 Joseph Luisier
(a) Residence, No. J. C. Home St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Sweed
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 1 - 1867
7. AGE YEARS 72 MONTHS 0 DAYS 3 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. Unknown
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) Sweeden

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweeden

17. INFORMANT (ADDRESS) Ernest Jackson
18. BURIAL, CREMATION, OR REMOVAL
PLACE K. Colo of Ort & Surg DATE Apl 27 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Kettler Eng K. C. Mo
20. FILED 4/29/1939 Sam G. Barnes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 4 1939
22. I HEREBY CERTIFY, That I attended deceased from 3-1, 1939 to 4-4, 1939
I last saw h— alive on 4-3, 1939 Death is said to have occurred on the date stated above, at 12 10 P.m.
The principal cause of death and related causes of importance were as follows:
chronic myocarditis
93 C
Date of onset
Other contributory causes of importance:
Name of operation Clinical Date of
What test confirmed diagnosis? Was there an autopsy? No

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? No
If so, specify
(Signed) J. W. Greene, M. D.
(Address) Independence Mo

(Licensed Embalmer's Statement on Reverse Side)

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 con with the above constitutes grounds for revocation of license.)

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