

1939 JUL 14

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

22655
Do not use this space.

1. PLACE OF DEATH
 (a) County Marion Registration District No. 547
 (b) Township Harmon Primary Registration District No. 3029 Registered No. 185
 (c) City Hannibal (d) Street No. Levee Hospital 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 75 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME Engel Christine Kaiser
 (a) Residence, No. 1900 Chestnut 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. George Kaiser
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 19 1863
 7. AGE YEARS 75 MONTHS 8 DAYS 9 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
 9. Industry or business in which work was done, as saw mill, bank, etc. At Home
 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) Germany Mo
 FATHER 13. NAME George Dehler
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany Mo
 MOTHER 15. MAIDEN NAME Marie Schweibert
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
 17. INFORMANT (NAME) (ADDRESS) J. George Kaiser, Jr.
Champaign, Ill.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Revere DATE June 12 39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ray P. Schwartz
Hannibal, Mo.
 20. FILED June 13 19 39 W. E. Fisher Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 10 1939
 22. 4/8 HEREBY CERTIFY That I attended deceased from 4/8 to 6/10 1939
 I last saw h.w. alive on 4/9 39 1939 Death is said to have occurred on the date stated above, at 7:20 a.m. 7:20
 The principal cause of death and related causes of importance were as follows:
Generalized Cardiovascular Failure About 4/3/39
Myocardial Infarction About 4/3/39
 Other contributory causes of importance:
Terminal Pneumonia 4/9/39
 Name of operation NO Date of _____
 What test confirmed diagnosis Clement's Laboratory 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. E. Sultzman M. D.
 (Address) Hannibal Mo

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.

64
5

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, _____

Cecil E. Schwartz

or by _____

Registered Apprentice No. *2338*, working under my personal supervision.

Signed *Cecil E. Schwartz*

Licensed Embalmer No. *23380*

P. O. Address *Hannibal, Mo*

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.