

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

24722
Do not use this space.

1939 AUG 7 1939

1. PLACE OF DEATH

(a) County Jackson Registration District No. 395
 (b) Township Kaw Primary Registration District No. 1007
 (c) City Kansas City (d) Street No. St. Marys Hospital Registered No. 2035
 (e) Length of residence in city or town where death occurred 26 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Mrs. Mary Magdaline Waizenegger.
 (a) Residence, No. 1811 East 58th St. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Julius Waizenegger.
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 22, 1865
 7. AGE YEARS 74 MONTHS 5 DAYS 25 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.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/17, 1939
 22. I HEREBY CERTIFY, That I attended deceased from 12-21, 1938, to 7/17, 1939
 I last saw her alive on 7/17, 1939 Death is said to have occurred on the date stated above, at 10:20 p.m.
 The principal cause of death and related causes of importance were as follows:

Carcinoma of Stomach
440-884
46
 Date of onset
 Other contributory causes of importance:
arteriosclerotic heart disease 410-516

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany. 6
 FATHER 13. NAME John Leibinger. 6
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany. 6
 MOTHER 15. MAIDEN NAME Anelia Stehle.
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany.

Name of operation _____ Date of _____
 What test confirmed diagnosis? Fluoroscope Was there an autopsy? no

17. INFORMANT (ADDRESS) Mrs. H. B. Nixon (Daughter)
1811 East 58th St.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE 7/20/39.
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Melody McGilley.
K. C. Mo.

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 _____

20. FILED July 19, 39 M. M. Browne
Local Registrar.

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____ (Signed) Paul C. Stoesberg, M. D.
822 Angulo St (Address)
Kansas City, 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.

Thelma Lynn Bell

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.