No. 2
1-10-39
-17-39
X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB JUL 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21301

Registration District No. 8 6 — Primary Registration District No. 5120 — Registrar's No. 10

1. PLACE OF DEATH:
(a) County: BUCHANAN
(b) City or town: HALLS. WAYNE TW (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: HALLS, MO. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... In this community: 20 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO. (b) County: BUCHANAN
(c) City or town: HALLS. (If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: JACOB KRETZER 132
3. (b) If veteran, name war: NONE
3. (c) Social Security No.: NONE
4. Sex: MALE
5. Color or race: WHT
6. (a) Single, widowed, married, divorced: MARRIED
6. (b) Name of husband or wife: LILLIE MAE KRETZER
6. (c) Age of husband or wife if alive: 58 years
7. Birth date of deceased: DEC. (Month) 9th. (Day) 1856 (Year)
8. AGE: Years 83 Months 5 Days 24 If less than one day ..... hr. ..... min.
9. Birthplace: OREGON (City, town, or county) MO. (State or foreign country)
10. Usual occupation: FARMER
11. Industry or business: /
FATHER 12. Name: JOHN KRETZER
FATHER 13. Birthplace: BERLIN (City, town, or county) GERMANY (State or foreign country)
MOTHER 14. Maiden name: SUSAN VALENTINE
MOTHER 15. Birthplace: UNKNOWN (City, town, or county) GERMANY (State or foreign country)
16. (a) Informant: MRS. LILLIE MAY KRETZER
(b) Address: HALLS, MO.
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof: JUNE 4 40 (Month) (Day) (Year)
(c) Place: burial or cremation: DE KALB, MO.
18. (a) Signature of funeral director: FLEEMAN & SON INC
(b) Address: ST. JOSEPH, MO.
19. (a) June 4-40 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 3RD. year 1940 hour 9 minute 15 A.M.
21. I hereby certify that I attended the deceased from 5-29- 1940 to 6-3- 1940 that I last saw him alive on 6-2- 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: CORINARY THROMBOSIS =
Due to: SENILE ARTERO-SCLEROSIS
Due to: & BREAKING DOWN OF VESSELS OF HEART AND KIDNIES —
Other conditions: ✓ (Include pregnancy within 3 months of death)
Major findings: Of operations: NONE
Of autopsy: NONE

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): ✓
(b) Date of occurrence: ✓
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓ (Specify type of place)
While at work? ✓ (e) Means of injury: ✓
23. Signature: B B Simmons (M. D. or other) ✓
Address: St Joseph Mo Date signed: ✓

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
District File Number 7610-1006
Date Filed JUL 3 1940

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 C. G. Swan

Licensed Embalmer No. 4082

P. O. Address St Joseph

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

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