G. No. 2
-11-10-39
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 14 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24406

Primary Registration District No. 1002

Registrar's No. 3016

1. PLACE OF DEATH:

(a) County Jackson 1

(b) City or town K.C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Vineyard Park
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community ____ years, months or days) Rochele L. Kriss (1 11)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town K.C.
(If outside city or town limits write "RURAL")

(d) Street No. 2316 Agnes.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME ROCHELE L KRISS

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex fe 5. Color or race W 6. (a) Single, widowed, married, divorced ____

6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Nov (Month) 15 (Day) 1938 (Year)

8. AGE: Years 1 Months 8 Days 13 If less than one day ____ hr. ____ min.

9. Birthplace K.C. (City, town, or county) Mo (State or foreign country)

10. Usual occupation ____ 1

11. Industry or business ____

FATHER
12. Name Ernest Kriss 0
13. Birthplace Dallas (City, town, or county) Tex. (State or foreign country)

MOTHER
14. Maiden name Edith Maisel
15. Birthplace K.C. (City, town, or county) Mo (State or foreign country)

16. (a) Informant Ernest Kriss
(b) Address K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-40 (Month) (Day) (Year)
(c) Place: burial or cremation Schofield Cem

18. (a) Signature of funeral director H. Tigermanton
(b) Address K.C. Mo

19. (a) July 29, 1940 (Date received local registrar) (b) M.M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28 year 1940 hour 11-40 minute P M.

21. I hereby certify that I attended the deceased from July 21, 1940, to July 28, 1940; that I last saw her alive on July 28-40, 19__ and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchopneumonia	8 days
Due to: 53	
Due to: Cerebral tumor	
Other conditions: Primary Glioma (Include pregnancy within 3 months of death) Malignant	1 yr.

Major findings:
Of operations None
Of autopsy Refused

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 1

23. Signature J. E. Sheldon M.D. (M. D. or other)
Address 912 Walnut Date signed 7-29-40

(Licensed Embalmer's Statement on Reverse Side)

K.C. Mo

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 Francis Walton, Registered Apprentice No. 2744, working under my personal supervision.

Francis Walton,

Signed Ary J. K. Tigerman

Licensed Embalmer No. 2744

P. O. Address K.C. 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.