No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37775

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4373

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

1. PLACE OF DEATH
(a) County Jackson
(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3614 E 57 St. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ✓ (Specify whether 2
In this community 60 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 3614 E. 57 St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? 60 yrs. years.

3. (a) PRINT FULL NAME Nicholas G. Kaiser
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex M
5. Color or race Wh
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Ellanora Kaiser
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Aug (Month) 7 (Day) 1871 (Year)

8. AGE: Years 69 Months 3 Days 7 If less than one day ___ hr. ___ min.

9. Birthplace (City, town, or county) Luxembourg (State or foreign country)
10. Usual occupation Contractor
11. Industry or business ?
FATHER
12. Name Frank Kaiser
13. Birthplace (City, town, or county) Luxembourg (State or foreign country)
MOTHER
14. Maiden name no Record.
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Ellanora Kaiser
(b) Address 3614 E 57
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. St. Mary's
18. (a) Signature of funeral director Bentley Mortuary
(b) Address 5811 Troost Ave.
19. (a) 11-17-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11.14 day 14 year 1940 hour 9 am minute ___ M.
21. I hereby certify that I attended the deceased from 1920, 19__, to 1940, 19__; that I last saw him alive on Nov 14, 1940 and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Hemorrhage
Due to Arteriosclerosis
Due to 82 ...
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations J. R. Hall
Of autopsy 626 Lathrop Bldg.

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 (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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, or by .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed Guy Buffington

Licensed Embalmer No. 2756

P. O. Address K. C. Mo.

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

If this body is not embalmed, fact should be so stated above.