

2
3-40
-39
K23159

Registration District No. **399**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH

(a) **City** Jackson

(b) City or town Kan. Con City Mo

(c) Name of hospital or institution 4116 Park Ave 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4.5 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Elizabeth Kistler

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Fe.

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife John Kistler

6. (c) Age of husband or wife if alive 5 - 1852 years (Day) (Year)

7. Birth date of deceased May (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>6</u>	<u>26</u>	hr. min.

9. Birthplace Ohio (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business

MOTHER FATHER

12. Name Suffner

13. Birthplace Penn (City, town, or county) (State or foreign country)

14. Maiden name Mary Ann

15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Berta Cuel

(b) Address 4116 Park Ave

17. (a) Burial (b) Date thereof Dec 3-40 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Bushman Jan Horn

(b) Address 4306 Mills Creek Rd

19. (a) 12-2-40 (Date received local registrar) (b) M. M. Orsille (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 4116 Park Ave. (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1 year 1940 hour 7 minute 4.5 P.M.

21. I hereby certify that I attended the deceased from _____, 1936 to 12/1, 1940 that I last saw her alive on 12/1, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial degeneration Duration 1 week

Due to Phasic myocarditis from arteriosclerosis

Due to Senility 930

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations _____
Of autopsy _____

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? 1

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Shaw Smith (M. D. or other) M.D.

Address 1107 Bryant Bldg. Date signed 12/2/40

Dr. Charles White
Bryant Bldg - Vic 0848
5957 - Passes - Ja 8223
Vac - 7500 - St. Louis
Li - 7000 St. Joseph

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, fact should be so stated above.