

FILLED OCT 15 1941

Registration District No. **464**Primary Registration District No. **#00 4274**Registrar's No. **17**

1. PLACE OF DEATH:

(a) County Lafayette
 (b) City or town Napoleon, Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution city
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME William H Kiso3. (b) If veteran, name war — 3. (c) Social Security No. —4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed7. (b) Name of husband or wife — 7. (c) Age of husband or wife if alive — years7. Birth date of deceased July 13 1871
(Month) (Day) (Year)8. AGE: Years 70 Months 1 Days 26 If less than one day hr. min.9. Birthplace Pears (City, town, or county) Mo (State or foreign country)10. Usual occupation Laborer11. Industry or business —12. Name John C. Kiso13. Birthplace Germany (City, town, or county) (State or foreign country)14. Maiden name Hannah Wells15. Birthplace Germany (City, town, or county) (State or foreign country)16. (a) Informant Virgil B. Kiso(b) Address Napoleon, Mo17. (a) Burial (b) Date thereof 9-12-41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Pears, Mo18. (a) Signature of funeral director Winkler(b) Address Keosauqua, Mo19. (a) (Date received local registrar) 111 (b) (Registrar's signature) 111

111 (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette
 (c) City or town Napoleon
 (If outside city or town limits, write "RURAL")
 (d) Street No. city (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9 year 1941 hour 1 minute 50 P.M.21. I hereby certify that I attended the deceased from Sept. 8-1941 to Sept. 9th 1941 that I last saw him alive on Sept. 9th 1941 and that death occurred on the date and hour stated above.Immediate cause of death Coronary thrombosis Duration —Due to —Other conditions (include pregnancy within 3 months of death) 94-NMajor findings: Of operations — PHYSICIAN —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? —While at work? (Specify type of place) (b) Means of injury —23. Signature R.B. Walts (M. D. or other) —Address Wellington Mo Date signed 9/11/41

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

400

10-8-51
X225

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-13-41

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 *John A. M. Kean*

Licensed Embalmer No. 2983

P. O. Address *Livingston, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31899

Registration District No. 466

Primary Registration District No. 4276

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Napoleon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

William H. Kiss

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased July 13 1876
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 15 (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sept 11 (b) F. P. Mearns
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day _____ year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

SUPPLEMENTARY

S-31899 1941