

FILED MAY 22 1942

State File No. \_\_\_\_\_

Registration District No. 280

Primary Registration District No. 5530

Registrar's No. 5

1. PLACE OF DEATH

(a) County Howard  
(b) City or town Rural  
(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 4 1/2 mo. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Howard  
(c) City or town Rural  
(d) Street No. Near Estill Mo.  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Annia Wade Miller Kaiser

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Wm. Kaiser 6. (c) Age of husband or wife if alive 42 years  
7. Birth date of deceased Oct 3 - 1889 (Month) (Day) (Year)

8. AGE: Years 59 Months 7 Days 15 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Charles J. Miller

18. Birthplace Cooper Co. (City, town, or county) (State or foreign country)

14. Maiden name W. O. Shipley

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

16. (a) Informant Georgia H. Light

(b) Address 224 Madison Jefferson City

17. (a) Rural (b) Date thereat 5/19/42 (Month) (Day) (Year)

(c) Place: burial or cremation Woolridge Mo.

18. (a) Signature of funeral director A. S. Kaiser

(b) Address New Franklin Mo  
19. (a) May 19, 1942 (b) Thomas Denny (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19 year 1942 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from Apr 13, 1942, to May 17, 1942 that I last saw h.e.R. alive on May 17, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis & myocardial degeneration

Due to mitral Regurgitation

Other conditions (Include pregnancy within 3 months of death) 930

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 OX  
23. Signature M. A. Jones (M. D. or other) P.D.  
Address Boonville Mo. Date signed 5-18-42

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

15  
00

1224

RECEIVED

District Health Officer No. 8r

District File Number.....

Date Filed 5-21-47

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**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, above space should be left blank.**