

FILED AUG 7 1943

Registration District No. 119

Primary Registration District No. 4192

Registrar's No. 7

1. PLACE OF DEATH:

(a) County GASCONADE
(b) City or town MORRISON
(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 57 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Joseph N. Kanner

3. (b) If veteran name war L 3. (c) Social Security No. ✓

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Sophia Kanner 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 28 1855 (Month) (Day) (Year)

8. AGE: Years 87 Months 6 Days - If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired farmer

11. Industry or business _____
12. Name unknown
13. Birthplace Switzerland (City, town, or county) (State or foreign country)
14. Maiden name Agat Kieck
15. Birthplace Switzerland (City, town, or county) (State or foreign country)

16. (a) Informant Sophia Kanner

(b) Address Morrison Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Morrison Mo

18. (a) Signature of funeral director Orval Hummel

(b) Address Morrison Mo

19. (a) July 4 1943 (b) A. H. Siedler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 28th
year 1943 hour 6 minute 5 PM.

21. I hereby certify that I attended the deceased from 6/7 1943 to 6/26 1943
that I last saw him alive on 6/26/43 and that death occurred on the date and hour stated above.

Immediate cause of death CIRCULATORY FAILURE

Due to MYOCARDIOSIS

Due to SEMITY & ARTERIOCLEROSIS

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

Major findings: Of operations 9322
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? _____ (Specify type of place)

23. Signature B. E. von Bastian (M. D. or other) _____

Address Morrison, Missouri Date signed 6/29/43

Duration

INDETERMINATE

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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..... *Chas. N. Pope*
Licensed Embalmer No. *2552*
P. O. Address *Morrison, 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.