

FILED JAN 19 1945

Registration District No. 147

Primary Registration District No. 5569

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

Registrar's No. 184

1. PLACE OF DEATH: Jackson

(a) County: Jackson

(b) City or town: Kansas City ~~Kansas~~ *Kansas*

(c) Name of hospital or institution: Raytown Road & Bannister Road  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 60 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: Missouri Jackson 48

(a) State: Missouri (b) County: Jackson

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

(d) Street No.: Raytown Rd and Bannister Road  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: \_\_\_\_\_

3. (a) PRINT FULL NAME: EDWARD S. LAITNER

3. (b) If veteran, name war: No

3. (c) Social Security No.: 493-14-8063

4. Sex: Ma U

5. Color or race: Wh

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Weltha Laitner

6. (c) Age of husband or wife if alive: XX years

7. Birth date of deceased: January 3 1874  
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 27  
If less than one day hr. min.

9. Birthplace: Detroit Michigan  
(City, town, or county) (State or foreign country)

10. Usual occupation: Retired Plumber

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

12. Name: Lorenz Laitner

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

14. Maiden name: Barbara Reuter

15. Birthplace: Cincinnati Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant: Lorenz Laitner

(b) Address: 3326 Charlotte

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof: 1-3-45  
(Month) (Day) (Year)

(c) Place: burial or cremation: Forest Hill

18. (a) Signature of funeral director: J. W. Wagner

(b) Address: Kansas City, Mo.

19. (a) 1/2/45 (Date received local registrar)

(b) Mildred Darwin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec 30, 1944 day: 30, 1944  
year: 1944 hour: 8:30 minute: 0 M.

21. I hereby certify that I attended the deceased from Oct 2, 1944 to Dec 30, 1944, that I last saw him alive on Dec 19, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death: acute Angina Pectoris  
Myocarditis (Chronic)  
Arterio Sclerosis especially of Cerebral region

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: C. Reilinger (M. D. or other)

Address: 311 Duquesne Bldg. Date signed: Jan 1, 1945

Duration: 12 1/2 years

PHYSICIAN: \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

M. 2  
-M  
1

RECEIVED

JAN 26 1945

**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 Cecil R. Matthes

Licensed Embalmer No. 3887

P. O. Address Kansas City, 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.**

Registration District No. 147

Primary Registration District No. 5569

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town RURAL BROOKING  
(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)

3. (a) PRINT FULL NAME Edward S. Lutzner

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 \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 3 (Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days \_\_\_\_\_ 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Edward S. Lutzner (Registrar's signature)  
(Date received local registrar)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1984 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 \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

9-24-58