

FILED JUN 1 1945
 Registration District No. **199**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Joseph's Hospital **0**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 hours
(Specify whether years, months or days)

In this community 36 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Dean Stelle Rising

3. (b) If veteran, name war No 3. (c) Social Security No. NONE

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Zula Rising 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Oct. 29, 1883
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>6</u>	<u>13</u>	hr. min.

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

10. Usual occupation Doctor

11. Industry or business Self

MOTHER FATHER

12. Name Jesse H. Rising
 13. Birthplace Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Runyon
 15. Birthplace Nebraska
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Jesse D. Rising
 (b) Address 327 S. Van Brunt

17. (a) Burial (b) Date thereof 5/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.
 (b) Address Kansas City, Mo.

19. (a) 5-14-45 (b) Theraldine Holmes
(Date received local registrar) (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. 124 Benton
(If rural, give location)
 (e) Citizen of foreign country? No **0** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12 year 1945 hour 12 minute 00 **noon** M.

21. I hereby certify that I attended the deceased from Nov. 6 1939 to May 12 1945
 that I last saw him alive on May 12 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis **12 hrs.**
Duration

Due to _____

Due to _____ **94a**

Other conditions Arterial Hypertension
(Include pregnancy within 3 months of death)

PHYSICIAN

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?
(Specify type of place)

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

23. Signature Jesse D. Rising **O M.D.**
(M. D. or other)
 Address 1102 Grand, K.C., Mo. Date signed 5-12-45

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 H. B. Blackman
Licensed Embalmer No. 3639
P. O. Address KC 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.