

S. No. 2
1-8-43
5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 13 1945
Registration District No. 372

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18341
State File No. _____
Registrar's No. 79

Primary Registration District No. 372

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Marshall, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Pitzgibbon's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 11 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Saline
(c) City or town Slater
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. 1
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Grace Ethel Kreisel

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 Married

6. (b) Name of husband or wife Allen Kreisel
6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased Nov. 13 1913
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
31 4 24 hr. min.

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

10. Usual occupation Housewife

11. Industry or business !!!

MOTHER FATHER { 12. Name Earnest Beyer
13. Birthplace Warsaw Mo.
(City, town, or county) (State or foreign country)

{ 14. Maiden name Bessie Shell
15. Birthplace Warsaw Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Allen Kreisel
(b) Address Slater, Mo. R.F.D.

17. (a) Burial (b) Date thereof 5/9/1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cole Camp Mo. Cemetery

18. (a) Signature of funeral director A. Leslie Swearing
(b) Address Marshall Mo.

19. (a) 5/8/45 (b) T.O. Hathorn, R.P.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 7
year 1945 hour 1:45 minute A M.

21. I hereby certify that I attended the deceased from 4 1945 to May 7 1945
that I last saw h. alive on May 6 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia
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:
(c) 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? _____ (e) Means of injury _____
23. Signature Edwin M. D. (M. D. or other)
Address Marshall, Mo. Date signed 5-7-45

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

6.1.2/12

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 *J. Leslie Sweeney*
Licensed Embalmer No. *3235*
P. O. Address *Marshall, 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.