. S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36818

FILED DEC 28 1945

Registration District No. ..... Primary Registration District No. 5184 Registrar's No. .....

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Rural (Whitewater Twp) (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3 Miles West of Millersville, Mo. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community Entire life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cape Gir.
(c) City or town Rural (Whitewater Twp) (If outside city or town limits, write "RURAL")
(d) Street No. 3 Miles West Millersville (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Marion S. Kistner
3. (b) If veteran, name war ✓
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 Parlee Kistner
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased June (Month) 11 (Day) 1869 (Year)
8. AGE: Years 76 Months 5 Days 5 If less than one day ..... hr. ..... min.
9. Birthplace Near Millersville (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farming
11. Industry or business .....
MOTHER FATHER
12. Name Henry Kistner
13. Birthplace Near Millersville (City, town, or county) Mo. (State or foreign country)
14. Maiden name Katherine Probst
15. Birthplace Near Millersville (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Albert Kistner Mo.
(b) Address Millersville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Russell Heights
18. (a) Signature of funeral director R. T. Miller
(b) Address Jackson
19. (a) 11-20-45 (Date received local registrar) (b) D. G. Sutter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 16 year 1945 hour 12 minute 40 A.M.
21. I hereby certify that I attended the deceased from 11/12, 1945 to 11/12, 1945 that I last saw him alive on 11/12, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	10 hr
Due to Arterial Sclerosis	15 yr ?
Due to Hypertension	15 yr ?
Other conditions Insanity - Cerebral Sclerosis (Include pregnancy within 3 months of death)	3 yr

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature T. E. Ruff (M. D. or other) MD
Address Jackson Mo Date signed 11/12/45

1432 (Licensed Embalmer's Statement on Reverse Side)

Health Officer No. 4

District File Number 1245-1410

Date Filed 12-7-45

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 J. E. Graham

Licensed Embalmer No. 4010

P. O. Address Kittsville, Me

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.