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5-17-39
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FILED OCT 7 1947

Registration District No. **47**

Primary Registration District No. **5162**

Registrar's No. **342**

1. PLACE OF DEATH:
 (a) County **Callaway Co.**
 (b) City or town **Stephens Mo**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **1 No. Cleveland**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **Life** years, months or days

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

3. (a) PRINT FULL NAME **Elizabeth Kistler**
 3. (b) If veteran, name war **X Y**
 3. (c) Social Security No. **X X**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **27th** year **1947** hour **3.15** minute **PM**
21. I hereby certify that I attended the deceased from **9-26-47** **9-11-47**
 that I last saw her alive on _____ and that death occurred on the date and hour stated above.

4. Sex **F** **5. Color or race** **W**
6. (a) Single, widowed, married, divorced **W 2**
6. (b) Name of husband or wife **Harry J. Kistler**
6. (c) Age of husband or wife if alive **Dead** years
7. Birth date of deceased **Feb 2 1855**
 (Month) (Day) (Year)

Immediate cause of death **Coronary on left chest** Duration _____
General Exam

8. AGE: Years **92** Months **7** Days **25** If less than one day _____ hr. _____ min.

Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings: **none**
 Of operations _____
 Of autopsy _____

9. Birthplace **Estell Kentucky**
 (City, town, or county) (State or foreign country)
10. Usual occupation **House Keeper**

PHYSICIAN
 Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name **Wm Griffiths**
13. Birthplace **Wales 4**
 (State or foreign country)
14. Maiden name **Sarah Powell**
15. Birthplace **Wales 4**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs W H Griffiths**
(b) Address **7139 W Broadway Columbia**
17. (a) Burial (b) Date thereof **Sept 28 47**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Chapel - Callaway Co**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence **10**
(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? _____

18. (a) Signature of funeral director **R Powell**
(b) Address **Columbia Mo**
19. (a) 9-28-1947 (b) **Joe Monahan**
 (Date received local registrar) (Registrar's signature)

While at work? **No** (Specify type of place) _____
(c) Means of injury _____
23. Signature **W P. Bryant** (M. D. or other)
Address **Columbia Mo** Date signed **9/28/47**

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

Date Filed 10-6-47

District File Number

District Health Officer No. 9,

RECEIVED

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, ~~only~~

....., Registered Apprentice No.
working under my personal supervision.

Signed Lyman Sprinkle

Licensed Embalmer No. 4013

P. O. Address Columbia, 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.