

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

33033

FILED NOV 4 1948

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4181

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 mo. 26 days
(Specify whether
 In this community 52 yrs
years, months or days)

3: (a) PRINT FULL NAME Harry H. Niswander

3. (b) If veteran, name war no 3. (c) Social Security No. 702-12-3639

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Berna May Niswander
 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased Oct-23 1898
(Month) (Day) (Year)

8. AGE: Years 52 Months 11 Days 20
 If less than one day hr. min.

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

10. Usual occupation Trans Railway Express Co

11. Industry or business _____

12. Name Jacob S Niswander

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

14. Maiden name Alice Dehoney
(City, town, or county) (State or foreign country)

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

16. (a) Informant Alice Niswander

(b) Address Heavenly Oaks

17. (c) Burial (b) Date thereof Oct-14-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Wm C L Foster

(b) Address 918 Broadway

19. (a) 10-14-48 (b) Seraldine 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. 127 So. Kensington
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 13
 year 1948 hour 6 minute 25 AM

21. I hereby certify that I attended the deceased from Aug. 17, 1948 to Oct. 13, 1948
 that I last saw him alive on Oct. 13, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of left lung

Due to _____

Due to _____

Other conditions HT
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See above

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 Wm W Hart (M. D. or other) _____
 Address Med. Dir. Gen'l Hosp. Date signed 10-14-48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1949
MAY 3

Dr. Farrell

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 *Dean Owens*

Licensed Embalmer No. *1280*

P. O. Address *K. C., 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.