

P. 300  
10-47  
17-39  
I 3333

Registration District No. 149

Primary Registration District No. 1002

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: MENORAH HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 MONTH  
(Specify whether years, months or days) ~~2 1/2 YEARS~~ June 1948

3. (a) PRINT FULL NAME MR. HERMAN J. PREISLER

3. (b) If veteran, name war No

3. (c) Social Security No. 487-05-5684

4. Sex MALE (1) 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS. HELEN E. PREISLER

6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased JULY 25 1910  
(Month) (Day) (Year)

8. AGE: Years 38 Months 3 Days 23  
hr. min.

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

10. Usual occupation ELECTRICIAN

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name HERMAN R. PREISLER

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

14. Maiden name MARIE SCHILLER

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

16. (a) Informant MRS. HELENE E. PREISLER

(b) Address 4238 BELLEFONTAINE

17. (a) BURIAL (b) Date thereof NOV. 20 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK CEM.

18. (a) Signature of funeral director J. H. Houckman's son

(b) Address 1401 BRUSH CREEK BLDG.

19. (a) 11-19-48 (b) Geraldine Holman  
(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. 4238 Bellefontaine  
(If rural, give location)

(e) Citizen of foreign country? YES (Yes or No)  
If yes, name country AUSTRIA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER Day 18<sup>TH</sup>  
year 1948 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from 11-17-48  
19\_\_\_\_ to 11-18, 1948  
that I last saw him alive on 11-17, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Addison's Disease Duration 2 3/4

Due to Tuberculosis pulmonary

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 13.5  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature B. M. Heller (M. D. or other)  
Address 416 Bryant Bldg Date signed 11-19-48

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

---

**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 Edward M. Storey

Licensed Embalmer No. 4452

P. O. Address K. C. 4 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.**