

FILED MAY 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **14978**

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>505</u>		
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>14 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #2</u>				d. STREET ADDRESS (If rural, give location) <u>323 North 15th St.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>H.</u>		b. (Middle) <u>BENJAMIN</u>		c. (Last) <u>KITZENBERGER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 11, 1954</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov. 20, 1886</u>		
9. AGE (In years last birthday) <u>67</u>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Electric Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>M. K. Electric Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Lyon County, Kans.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Gottlieb Kitzenberger</u>		13b. MOTHER'S MAIDEN NAME <u>Wilhemina Bofinger</u>		14. NAME OF HUSBAND OR WIFE <u>Elinor E. Kitzenberger</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>489-36-1634</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Elinor E. Kitzenberger, St. Joseph, Mo</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Psychotic</u>					INTERVAL BETWEEN ONSET AND DEATH. <u>Mar. 17, 1954</u> <u>3 yrs.</u> <u>14 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331 X</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Joseph Buchanan Missouri</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Mar 17, 1954 ? m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell in home.</u>				
22. I hereby certify that I attended the deceased from <u>May 10, 1954</u> , to <u>May 11, 1954</u> , that I last saw the deceased alive on <u>May 10, 1954</u> , and that death occurred at <u>3:45A m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>C. E. Coasine, M.D.</u>				23b. ADDRESS <u>State Hospital #2, City</u>		23c. DATE SIGNED <u>5-11-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 13, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>May 19, 1954</u>		REGISTRAR'S SIGNATURE <u>Catherine M. Allison</u>		5. FUNERAL DIRECTOR'S SIGNATURE <u>Meurshoff - Sherman</u>		ADDRESS <u>St. Joseph, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

1908-1915

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Raymond W. Morehead

Licensed Embalmer No. 4413

P. O. Address Joseph M.

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.