

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30664**  
**4085**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>Kansas City</b>	c. LENGTH OF STAY (in this place) <b>58 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>644 West 57th St.</b>		STREET ADDRESS (If rural, give location) <b>82 644 West 57th St. 2828</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>EUGENE</b> b. (Middle) <b>A.</b> c. (Last) <b>KIGER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 23, 1954</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 30, 1889</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jewelry Co.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Hutchinson, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>Charles Kiger</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Helen Wineger Kiger</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>486-05-0309</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Helen Kiger, 664 W. 57th, K. C., Mo.</b>	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>
	ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>4201</b>

19a. DATE OF OPERATION <b>—</b>	19b. MAJOR FINDINGS OF OPERATION <b>—</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Kansas City, Jackson, Missouri</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>—</b>

22. I hereby certify that I attended the deceased from **August 21, 1954**, to **August 23, 1954**, that I last saw the deceased alive on **August 21, 1954**, and that death occurred at **12:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Robert E. Allen, MD.</b>	(Degree or title)	23b. ADDRESS <b>411 Nichols Rd. Kansas City, Mo.</b>	23c. DATE SIGNED <b>August 24, 1954</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>8-25-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>	24d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
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DATE REC'D BY LOCAL REG <b>8-25-54</b>	REGISTRAR'S SIGNATURE <b>Sheraldine Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>STINE &amp; McCLURE UND. CO.</b>	ADDRESS <b>K.C.MO.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Received from W. Allen  
Tonic Blage  
No. 2989*

*at 2:00 Sharp at his office today.*

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: .....  
Signature of Student Embalmer

Signed *F. S. Waller* .....

Licensed Embalmer No. *27* .....

P. O. Address *K.C.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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.