

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36897**
4718
Registrar's No.

FILED NOV 23 1955

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 202

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Kansas b. COUNTY Neosho	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Chanute	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 Mo		e. STREET ADDRESS (If rural, give location) 1839 Benton	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #2			

3. NAME OF DECEASED (Type or Print) a. (First) Gertrude b. (Middle) _____ c. (Last) Kaizer			4. DATE OF DEATH (Month) 11 (Day) 1 (Year) 1955		
5. SEX 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH 2-11-77	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Lane, Kansas		12. CITIZEN OF WHAT COUNTRY? America
13a. FATHER'S NAME Steven Webster		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE John Kaiser	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Floyd Crith ADDRESS 1839 Benton	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia		INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Malnutrition & dehydration.		491X
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 10-30-55, 1955, to 11-1-55, 1955, that I last saw the deceased alive on 11-2-55, 1955, and that death occurred at 3:15 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E. Frank Ellis MD		23b. ADDRESS 600 East 22nd Street		23c. DATE SIGNED 11-2-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11-2-55	24c. NAME OF CEMETERY OR CREMATORY Elmwood-Chanute, Kan.	24d. LOCATION (City, town, or county) (State) Chanute, Kansas	
DATE REC'D BY LOCAL REG. 11-3-55	REGISTRAR'S SIGNATURE Neve Marshall	25. FUNERAL DIRECTOR'S SIGNATURE Matthews Bros 18th & Benton ADDRESS		

WRITE PLAINLY—USING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Bruce R Wattain*

Licensed Embalmer No. *456*

P. O. Address *18th St Ba*

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.