

Health,  
Welfare  
Public  
Service

FILED AUG 23 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

282 17 28  
STATE FILE NUMBER  
3645

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3645

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, give TOWNSHIP only) OR <b>Kansas City</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>927 W. 42nd St.</b>		Length of stay in 1b <b>15 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>927 W. 42nd St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>FREDRICK</b> Last <b>KREGER</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>1st</b> , Year <b>1957</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1899</b>	9. AGE (In years last birthday) <b>58</b>	FUNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book-keeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Everett, Mass.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>M. Hope Kreger</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>Yes World War I</b>	16. SOCIAL SECURITY NO. <b>293-07-0959</b>	17. INFORMANT Address <b>Mrs. M. Hope Kreger, Kansas City, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
DUE TO (b) <b>Congestive heart failure.</b>		
DUE TO (c) _____		<b>6 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a), (b), and (c).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from <b>July 27-1957</b> to <b>Aug 1-1957</b> and last saw her alive on <b>Aug 1-1957</b> . Death occurred at <b>11:57 P.M.</b> m on the date stated above; and to the best of my knowledge, for the causes stated.	
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22a. SIGNATURE <b>R. M. Lilley DO.</b>	(Degree or title) <b>2</b>	22b. ADDRESS <b>3915 Main St. Kansas City Mo</b>	22c. DATE SIGNED <b>8-2-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug. 5, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jackson County, Missouri</b>
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24. FUNERAL DIRECTOR <b>FREEMAN MORTUARY, Kansas City, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>8-3-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

R. M. Lilley  
MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
All diseases in Part I must be causally related.

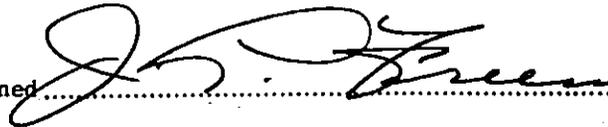
3-5:30 PM.  
FR.



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  .....

Licensed Embalmer No. 293  
P. O. Address J. B. Green

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.