

Dept. Health,
Inc., & Welfare
U. S. Public
Health Service

FILED JAN 17 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

47301
STATE FILE NUMBER
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6090

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Length of stay in lb 65 YEARS	d. STREET ADDRESS 5341 Myrtle (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last JOSEPH WILLIAM KRITZER			4. DATE OF DEATH Month Day Year December 20, 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep. 18, 1892		9. AGE (In years last birthday) 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) KANSAS CITY, MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME FRANK W. KRITZER		13b. MOTHER'S MAIDEN NAME MRS. PHINEAS JEWELL		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW I		16. SOCIAL SECURITY NO. 493-12-9560	17. INFORMANT Address Official Records VA Hospital, K.C., Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bronchopneumonia. Arteriosclerotic heart disease with congestive heart failure. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) Cerebral vascular accident.					INTERVAL BETWEEN ONSET AND DEATH 4200
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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	
21. I attended the deceased from Dec 7, 1957 to Dec 20, 1957 and last saw him/her alive on Dec 20, 1957 Death occurred at 7:40 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Eugene M. Malone (Degree or title) M.D.			22b. ADDRESS VA HOSPITAL, K.C., Mo.		22c. DATE SIGNED 12-21-57
23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		23b. DATE DEC. 23, 1957	23c. NAME OF CEMETERY OR CREMATORY GREEN LAWN CEMETERY		23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS.		ADDRESS 1331 BRUSH GREEN KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 12-23-57		26. REGISTRAR'S SIGNATURE Neva Minshall

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
 All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Eugene M. Malone



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 *Norman W. Peterson*

Licensed Embalmer No. *4859*
P. O. Address *D. C., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.