

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001384

STATE FILE NUMBER

FILED FEB 5 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 369

300  
-57

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 TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>8124 EAST 80th Terr</b>	
Length of stay in lb <b>13 Yrs</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>OTTO L KREISER</b>			4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1907</b>	9. AGE (In years last birthday) <b>51</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done or profession, trade, occupation, or retired) <b>Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpentry</b>		11. BIRTHPLACE (City and state or country) <b>Phillipsburg, Kansas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>		13a. FATHER'S NAME <b>Samuel Levi Kreiser</b>		13b. MOTHER'S MAIDEN NAME <b>Inez Belle Waldon</b>	
13c. NAME OF HUSBAND OR WIFE <b>Alta Kreiser</b>		14. NAME OF HUSBAND OR WIFE <b>Alta Kreiser</b>			

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If <b>W</b> , give year or dates of service) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>511 09 662+</b>	17. INFORMANT Address <b>Mrs. Alta Kreiser 8124 E. 80th. Terr</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 <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 Years.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO <b>General Marked Occlusive Coronary atherosclerosis.</b> DUE TO <b>myocardial Infarction-acute</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>10</b> <b>1) myocardial Infarction - 3-4x</b> <b>2) Chronic Congestive Heart Failure (9 months)</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY Hour <b>9.00P</b> Month <b>Jan</b> Day <b>19</b> Year <b>1959</b>	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 <b>Kansas City</b>		STATE <b>Missouri</b>

21. I attended the deceased from <b>April 2, 1958</b> to <b>19 JAN. 1959</b> and last saw her alive on <b>Jan. 7, 1959</b> Death occurred at <b>9.00P</b> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <b>Philip G. Kaul MD.</b>	22b. ADDRESS <b>411 Nichols Road</b>	22c. DATE SIGNED <b>1-20-59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-22-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>	23d. LOCATION (City, town, or country) (State) <b>Kansas City Missouri</b>
24. FUNERAL DIRECTOR <b>Floral Hills Memorial Chapels, Inc</b>		25. DATE RECD. BY LOCAL REG. <b>1-20-59</b>	26. REGISTRAR'S SIGNATURE <b>new mitchell</b>

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Phillip G. Kaul

All diseases in Part I must be causally related.

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, ~~on~~....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Forrest D. Goldman*.....

Licensed Embalmer No. *4714*.....

P. O. Address *K.P. 7ms*.....

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.