

S. No. 2
-9441
5-17-33
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30525

State File No. _____

FILED SEP 21 1943

Registrar's No. 3842

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City Missouri

(c) Name of hospital or institution: 5949 Paseo /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: _____ (Specify whether years, months or days) 20 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City Missouri
(If outside city or town limits, write "RURAL")

(d) Street No.: 5949 Paseo
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: _____

3. (a) PRINT FULL NAME: Mr William BREIER

3. (b) If veteran, name war: None 3. (c) Social Security No.: None

4. Sex: Male 5. Color or race: White 6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Anna Breier 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: December 29th 1852
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	90	8	7	_____ hr. _____ min.

9. Birthplace: Unknown Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation: Contractor Brick & Bldg

11. Industry or business: At St v Joseph Missouri

12. Name: John Breier

13. Birthplace: Unknown Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name: Unknown

15. Birthplace: Unknown Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Louis Webster

(b) Address: 5949 The Paseo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-9-43
(Month) (Day) (Year)

(c) Place: burial or cremation: St. Joseph

18. (a) Signature of funeral director: Melody McGilley

(b) Address: Kansas City Missouri

19. (a) 9-7-43 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: September Day: 6th
Year: 1943 hour: 8:45 minute: 8 M.

21. I hereby certify that I attended the deceased from ~~Sept 5~~ ^{Sept 5} 1939 ^{Sept 5} 1940
that I last saw him alive on ^{Sept 5} 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac renal Duration: 127

Due to: arteriosclerosis

Due to: old age 131a

Other conditions: Enlarged Prostate
(Include pregnancy within 3 months of death)

Major findings: Possible Malignancy

Of operations: _____

Of autopsy: NO

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury: _____

23. Signature: J. J. Amworth (e) D. or other: _____
Address: 7300 W. 12th Date signed: 9/7/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.