

No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9318

FILED APR 1 1947

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1279

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
General Hospital No. 1 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether years, months or days)

In this community 31 yrs.

3. (a) PRINT FULL NAME Katie Pierron

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Fem. / race Wh

5. Color or race Wh

6. (a) Single, widowed, married, divorced Wid. 2

6. (b) Name of husband or wife Peter Pierron

6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased 3/3/1893
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>54</u>	<u>0</u>	<u>14</u>	<u>hr. min.</u>

9. Birthplace Milwaukee, Wisc.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business //

MOTHER FATHER

12. Name Phillip J. Kraus

13. Birthplace Unk 9
(City, town, or county) (State or foreign country)

14. Maiden name Mary Bensfeld

15. Birthplace Unk 9
(City, town, or county) (State or foreign country)

16. (a) Informant John Pierron

(b) Address 5437 E. 11th St.,

17. (a) Burial (b) Date thereof 3/20/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galvary Cemetery

18. (a) Signature of funeral director John F. Sheil

(b) Address K. C. MO.

19. (a) 3-19-47 (b) Stroddine Holme
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 5437 E. 11 St. 8
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17
year 1947 hour 9 minute A. M.

21. I hereby certify that I attended the deceased from March 7, 1947, to March 17, 1947
that I last saw her alive on March 17, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular accident

Due to _____

Due to _____

Other conditions 830
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy See above

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? U

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

23. Signature Wm W Hart (M. D. or other) 3-17-47

Address Med. Dir. Gen'l Hosp. Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 John R Steel
Licensed Embalmer No. 3625-
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.