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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35649

State File No. _____

Registration District No. 439

Primary Registration District No. 5596

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Knox
(b) City or town Greensburg
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Greensburg, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 60 years.
years, months or days)

3. (a) PRINT FULL NAME Wm. H. Kaser

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jessie A. Starbuck 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased Aug- 2 - 1855.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 2 I. _____ hr. _____ min.

9. Birthplace Lansing Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name John Kasper Kaser
13. Birthplace Aron Conton Switzerland.
(City, town, or county) (State or foreign country)
14. Maiden name Louisa Bertchi.
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Hester L. Kaser
(b) Address Baring Mo

17. (a) Burial (b) Date thereof Oct-50 1940.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Ridge.

18. (a) Signature of funeral director Edna M.

(b) Address Keith Hudson

19. (a) Oct 4 1940 (b) Mrs C.M. Smith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Knox
(c) City or town Greensburg
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3
year 1940 hour 10 minute P.M.

21. I hereby certify that I attended the deceased from May 2
1940, to Oct 3, 1940

that I last saw him alive on Oct. 3, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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?
395 _____

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

23. Signature Dr. E. E. Symmonds (M. D. or other) MD

Address Memphis Mo Date signed Oct 4

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

1940

RECEIVED

District Health Officer No. 10

District File Number 11-10-2180

Date Filed NOV 14 1940

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

Keith Hudson

Licensed Embalmer No. 2415

P. O. Address Edina, Minn.

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, above space should be left blank.