

S. No. 2
M-1-4-4
v. 5-17

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. **15036**

FILED MAY 14 1941

Registration District No. 475

Primary Registration District No. 5639

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Verona
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Verona Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Hospital 4 wks
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence 35
(c) City or town Aurora
(If outside city or town limits, write "RURAL")
(d) Street No. Summit City Hotel
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William H Kessinger

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

4. Sex Male 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Minnie Kessinger
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased March 10 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 2 0 hr. min.

9. Birthplace Raymore Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Hotel Mgr.

11. Industry or business Hotel

MOTHER FATHER { 12. Name A. B. Kessinger
13. Birthplace ? Ind.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Skyles
15. Birthplace ? Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address Aurora Mo.

17. (a) Burial (b) Date thereof 5/11/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Aurora Mo.

18. (a) Signature of funeral director J. F. King
(b) Address Aurora Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10
year 1941 hour 12 minute 01 A. M.

21. I hereby certify that I attended the deceased from April 1, '41
May 10, 1941 to May 10, 1941
that I last saw him alive on May 10, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death
~~ENTRANCE OF STOMACH~~
Cardiac Failure
Due to Carcinoma of the Stomach
Due to Chronic Gastric Ulcers

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?

426 (Specify type of place) (e) Means of injury _____
While at work? _____
23. Signature F. Avery Watson (M. D. or other) D.O.
Address Verona, Missouri Date signed 5/10/41

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

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

RECEIVED

District Health Officer No. 6,

District File number 541-787

Date Filed MAY 13 1941

1941

DEPARTMENT OF HEALTH

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 Herna Surridge

Licensed Embalmer No. 3072

P. O. Address Aurora Me.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 475

Primary Registration District No. 2639

Registrar's No. _____

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Wm H. Kessinger
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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____ month _____ day

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 69 Months 2 Days 0 If less than one day _____ hr _____ min

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May-10-41 (b) A J Rudig (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH month May day 10
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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 Faurey Watson (M. D. or other)

Address Personia Mo Date signed _____

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

SUPPLEMENTAL

MOTHER FATHER

