No. 2
-8-43
-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9/1944

Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3038

State File No. 18531

Registrar's No. 329

1. PLACE OF DEATH:

(a) County Linn

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

(c) Name of hospital or institution: Brookfield Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 2½ hrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58

(c) City or town Bucklin 0
(If outside city or town limits, write "RURAL")

(d) Street No. —
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME ALBERT GEORGE KEZAR

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male

5. Color or race White

6. (a) Single, widowed, married, divorced — 0

6. (b) Name of husband or wife —

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

7. Birth date of deceased May (Month) 26 (Day) 1944 (Year)

8. AGE: Years — Months — Days — If less than one day 2 hr. 30 min.

9. Birthplace Brookfield (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation none

11. Industry or business none

FATHER
12. Name Georg Albert Kezar
13. Birthplace Macon Co (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Ethel Mae Watskey
15. Birthplace Linn Co. (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant George A. Kezar
(b) Address Bucklin Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (Month) 27 (Day) 44 (Year)
(c) Place: burial or cremation New Cambria Cemetery

18. (a) Signature of funeral director H. J. Gilleland
(b) Address New Cambria Mo.

19. (a) 5-26-44 (Date received local registrar) (b) W W Cannon (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May day 26
year 1944 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 26, 19 , to May 26, 19 44
that I last saw him alive on 5/26, 19 44
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Atelectasis	2 hrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 161a	

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

23. Signature C. C. Smith D.O. (M. D. or other)
Address Brookfield Mo. Date signed 5/26

(Licensed Embalmer's Statement on Reverse Side)

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 w the above constitutes grounds for revocation of license.)

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