

X37823

FILED JUL 12 1944

Registration District No. 204

Primary Registration District No. 5739

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Macon Co Mo.  
(b) City or town Richland Township  
(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 1 (Specify whether \_\_\_\_\_)  
In this community 90 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon Co  
(c) City or town Rural  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Sydia Emerine Kessinger

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

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Wm Kessinger 6. (c) Age of husband or wife if alive Dead years 1850  
7. Birth date of deceased Nov 27 1850 (Month) (Day) (Year)

8. AGE: Years 93 Months 7 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Home keeper

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Chas. Griffin  
13. Birthplace Macon Co, Mo. (City, town, or county) (State or foreign country)  
14. Maiden name Maney Richardson  
15. Birthplace Macon Co, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Carl J. Phillips  
(b) Address 2510 Holmes St Kansas City Mo

17. (a) Burial (b) Date thereof June 25 1944 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Morris Cemetery

18. (a) Signature of funeral director D. S. Christ  
(b) Address La Plata Mo.

19. (a) June 24-44 (b) Mrs. Louch (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22, 1944  
year \_\_\_\_\_ hour 11:45 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from June 11, 1944, to \_\_\_\_\_, 1944;

that I last saw him alive on June 16, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture femur. age.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
23. Signature C. H. Tucker (M. D. or other) \_\_\_\_\_  
Address La Plata Mo. Date signed 6-24-44

1057

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

**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 D. S. Christie

Licensed Embalmer No. 1109

P. O. Address La Plata New

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 204

Primary Registration District No. 5739

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Richland  
(c) Name of hospital or institution: Imp.  
(If outside city or town limits, write "RURAL" and name of township)

(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 \_\_\_\_\_

3. (b) If veteran, name war Lydell E. Messinger (c) Social Security \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased mo. 21  
(Month) (Day) (Year)

8. AGE: Years 93 Months 7 Days \_\_\_\_\_ Unless than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 July 21  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture femur Duration \_\_\_\_\_

Due to a fall in her bed-room on Jan. 29, 1944  
Due to at 4 A.M.

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 L. H. Buller (M. D. or other) \_\_\_\_\_  
Address La Plata Mo. Date signed 7-22-44

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

SUPPLEMENTARY

BUREAU OF CENSUS

1944 JUL 25 PM 1 54

ADMINISTRATIVE SERVICE  
DIVISION

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