S. No. 2
M—8-43
. 5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 11 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30389

Registration District No. ____ Primary Registration District No. 3000 Registrar's No. 256

1. PLACE OF DEATH:
(a) County: Adair
(b) City or town: Kirksville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Nursing Home (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 4 (Specify whether years, months or days) In this community: Six days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Clark
(c) City or town: Revere-Rural (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: 1

3. (a) PRINT FULL NAME: John E. Kautz
3. (b) If veteran, name war: ____ 3. (c) Social Security No. ____
4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: W divorced
6. (b) Name of husband or wife: Laura Kautz
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Feb. (Month) 7 (Day) 1859 (Year)
8. AGE: Years 85 Months 7 Days 23 If less than one day ____ hr. ____ min.
9. Birthplace: Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: Farming
11. Industry or business: ____
MOTHER FATHER
12. Name: Jacob Kautz
13. Birthplace: Germany (City, town, or county) (State or foreign country)
14. Maiden name: Barbara Herman
15. Birthplace: Germany (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. D. S. Kautz
(b) Address: Laplata Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-2-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Kahoka Mo.
18. (a) Signature of funeral director: Gathing and
(b) Address: Kahoka Mo.
19. (a) 10-2-44 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 30 year 1944 hour 7 minute 30 P. M.
21. I hereby certify that I attended the deceased from Sept 24, 1944, to Sept 30, 1944; that I last saw him alive on Sept 30, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Vascular collapse	20 hours
Due to: Cerebral Hemorrhage	20 hours
Due to:	
Other conditions (Include pregnancy within 3 months of death): 830	
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: M. T. Hutchison (M.D. or other) D.O.
Address: Kirksville, Mo. Date signed 9-30-44

1049 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-44-1722
Date Filed OCT 1 0 1944

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 W. C. Summers

Licensed Embalmer No. 2159

P. O. Address Kirksville Mo

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.