

S. No. 2
1-9-4-41
5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16368**

FILED MAY 24 1945

Registration District No. **42**

Primary Registration District No. **1005**

Registrar's No. **541**

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

1. PLACE OF DEATH:
 (a) County **Buchanan**
 (b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **10 days**
(Specify whether
 In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Harrison**
 (c) City or town **Pattonsburg Rural**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? **No. 1** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **James F. Kessinger**
 3. (b) If veteran, name war **✓**
 3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **May** day **13**
 year **45** 2 hour **30** minute **0** M.
 21. I hereby certify that I attended the deceased from **5-3-45** to **5-13-45**
 that I last saw him alive on **5-13-45**
 and that death occurred on the date and hour stated above.

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Mary Henry Kessinger** 6. (c) Age of husband or wife if alive **76** years
 7. Birth date of deceased (Month) **Feb** (Day) **9-18** (Year) **1868**

Immediate cause of death:
Myocardial Infarction
Coronary Artery Disease
 Due to _____
 Due to _____

8. AGE:	Years	Months	Days	If less than one day
	85	3	4	hr. min.

Other conditions:
Diabetes mellitus
Fractured right hip
 Major findings:
 Of operations _____
 Of autopsy _____

9. Birthplace **Harrison Co. Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Dr. Anna Mcelling**

(b) Address **Pattonsburg, Mo. 0**

17. (a) **Burial** (b) Date thereof **May 15-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bethel**

18. (a) Signature of funeral director **G. S. Grover**

(b) Address **Pattonsburg, Mo. 0**

19. (a) **5-15-45** (b) **Bethel J. Decker**
(Date received local registrar) (Registrar's signature)

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? **✓** Means of injury **5**

23. Signature **Dr. Joseph M. 041** (M. D. or other)
 Address **St. Joseph Mo** Date signed **5/15/45**

Duration
3
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

1377

(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 *will be* was embalmed by me, or by.....
..... Registered Apprentice No.....
working under my personal supervision.

Signed *G. S. Gomez*
Licensed Embalmer No. *2857*
P. O. Address *Pattonburg, N.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply v the above constitutes grounds for revocation of license.)

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 541

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(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)

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 _____

3. (a) PRINT FULL NAME James F. Kesinger
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 _____ years
7. Birth date of deceased Feb 9 1865
(Month) (Day) (Year)

8. AGE: Years 85 Months _____ Day _____ If less than one day _____ hr. _____ min.

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

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 5/3/45
(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)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
(that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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

Major findings: none
Of operations _____
Of autopsy none

Duration _____
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) Fracture of left hip
(b) Date of occurrence 5/3/45 from fall
(c) Where did injury occur? 5/3/45
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home

While at work? _____ (Specify type of place) (g) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Date signed _____

SUPPLEMENTARY

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

1103108

1103108

1103108

1103108