. S. No. 2
0M—2-43
ev. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33751

FILED NOV 13 1945

Registration District No. 126 Primary Registration District No. 5462 Registrar's No. 11

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town FAIR GROVE Sanitarium
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R.F.D. # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County GREENE
(c) City or town FAIR GROVE
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. # 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME ARTHUR U. KESTERSON
3. (b) If veteran, name war NONE
3. (c) Social Security No. NONE

4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MARY E. KESTERSON
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased AUG 13 1876 (Month) (Day) (Year)

8. AGE: Years 69 Months 1 Days 28 If less than one day ..... hr. ..... min.

9. Birthplace GREENE Co. (City, town, or county) MO. 0 (State or foreign country)
10. Usual occupation FARMER
11. Industry or business FARMING

MOTHER FATHER
12. Name David C. Kesterson
13. Birthplace Cleveland (City, town, or county) Ohio (State or foreign country)
14. Maiden name Minerva Kesterside
15. Birthplace Dade Co. (City, town, or county) Georgia (State or foreign country)

16. (a) Informant .....
(b) Address SPRINGFIELD MO.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Comfort Cem
18. (a) Signature of funeral director J.W. Klingner & Co.
(b) Address SPRINGFIELD MO.
19. (a) 10/13/45 (Date received local registrar) (b) Mrs Porter O'Dell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11 year 1945 hour 1 minute 30 A.M.
21. I hereby certify that I attended the deceased from ....., 1940, to Oct 11, 1945; that I last saw him alive on Oct 10, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardio Renal Vascular Disease	5 yr.
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? ..... (Specify type of place)
While at work? (e) Means of injury .....

23. Signature ..... (M. D. or other) MO
Address Springfield Mo. Date signed 10-12-45

(Licensed Embalmer's Statement on Reverse Side)

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RECEIVED
Greene County Health Office,
County File Number 45-11-81
Date Filed 11/8/45

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 Ogle Stone Jr.

Licensed Embalmer No. #176

P. O. Address Springfield

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.