

FILED OCT 27 1947 128

State File No.

Registration District No.

Primary Registration District No. 2000

Registrar's No. 897

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Burge Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days**
In this community **3 days**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene**
(c) City or town **Willard** "Rural"
(If outside city or town limits, write "RURAL")
(d) Street No. **R.R. # 2**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

John William Kesser Jr.

(b) If veteran, name war **None**

(c) Social Security No. **None**

4. Sex **M** Color or race **WHITE**

(a) Single, widowed, married, divorced **Single**

(b) Name of husband or wife

(c) Age of husband or wife if alive **11** years

7. Birth date of deceased **Oct 11 1947**
(Month) (Day) (Year)

8. AGE: Years **0** Months **0** Days **3**
If less than one day hr. min.

9. Birthplace **Springfield Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant at Home**

11. Industry or business

12. Name **John William Kesser**

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

14. Maiden name **Marie Sue Craig**

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

16. (a) Informant **Mrs. George Rosa**
(b) Address **2545 N. Fremont**

17. (a) **Burial** (b) Date thereof **Oct 15-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Quentalva**
(d) Signature of funeral director **W. Kingner & Co.**
(e) Address **Springfield Mo.**

19. (a) **10-15-47** (b) **W. E. Handwerker**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **14**th
year **1947** hour **1** minute **30** a.m.

21. I hereby certify that I attended the deceased from **10-12**, 19**47**, to **10-14**, 19**47**;
that I last saw him alive on **10-14**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Palsy**
Duration **3d**

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Of operations **None**

Of autopsy **None**

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 **None**

23. Signature **Dr. Busch** (M. D. or other)
Address **10-15-47 Springfield Mo.**

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

9
2

31
0
3

1

Duration

3d

PHYSICIAN

Underline the cause to which death should be charged statistically.

0

10-15-47

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

Max Rhodes
4071
Springfield

Licensed Embalmer No.

P. O. Address

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.