

FILED AUG 14 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23969

BIRTH NO. 54871-57 REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 253

1. PLACE OF DEATH a. COUNTY Pettis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Pettis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia, Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia, Route 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bothwell Memorial Hosp.		d. STREET ADDRESS (If rural, give location) Route 2	

3. NAME OF DECEASED a. (First) b. (Middle) c. (Last) Infant son Mr. & Mrs August J. Kaiser			4. DATE OF DEATH Aug 6, 1951 (Month) (Day) (Year)		
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5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH Aug 6, 1951	9. AGE (In years last birthday) 9	IF UNDER 1 YEAR Months 17	IF UNDER 24 HRS. Min. 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Sedalia, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME August John Kaiser	13b. MOTHER'S MAIDEN NAME Mildred Marie Lilly	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME August J. Kaiser, Sedalia, R 2	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 9 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Paralysis.		
	ANTECEDENT CAUSES Morbic conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Immaturity DUE TO (c) Multiple Pregnancy, twins		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 8-6-1951, to 8-6-1951, that I last saw the deceased alive on 8-6-1951, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

23a. SIGNATURE J. W. Rodeman, M.D.	(Degree or title)	23b. ADDRESS Sedalia, Missouri	23c. DATE SIGNED 8-6-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/7/51	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) Sedalia, Missouri
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DATE REC'D BY LOCAL REG. 8/19/1951	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Sedalia, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

804

RECEIVED 8-13-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 8-13-51

Dr. Rodman

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____
Student Embalmer

Signed *P. E. Baker*

Licensed Embalmer No. *2419*

P. O. Address *Sedalia*

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.