

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Johnson, M.D. **31328**
State File No. **869**

5. No. 300
v. 10.48
FILED SEP 29 1952

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2002 Registrar's No. 869

0396

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY DENT	
b. CITY OR TOWN SPRINGFIELD		c. LENGTH OF STAY (in this place)	
c. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHNS HOSPITAL		d. STREET ADDRESS (If rural, give location) /	

3. NAME OF DECEASED (Type or Print) a. (First) JAMES	b. (Middle) ALEXANDER	c. (Last) KISSOCK	4. DATE OF DEATH (Month) (Day) (Year) SEPT. 20, 1952
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 29, 1876	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 10 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (City and State or Foreign Country) Dent Co., Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME J. A. KISSOCK	13b. MOTHER'S MAIDEN NAME MARTHA CAROLIN BLACK ZENS KISSOCK	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. ?	17. INFORMANT'S SIGNATURE OR NAME Zens Kissock	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY THROMBOSIS	DUE TO (b) Suprapubic prostatectomy, postoperative		Immediate
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	DUE TO (c) Benign hypertrophy of prostate		5 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			many years

19a. DATE OF OPERATION 9-16-52	19b. MAJOR FINDINGS OF OPERATION Large Benign hypertrophy of prostate	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 610X
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22. I hereby certify that I attended the deceased from Sept. 10, 1952, to Sept. 20, 1952; that I last saw the deceased alive on Sept. 19, 1952, and that death occurred at 12:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE William F. Johnson, M.D.	(Degree or title)	23b. ADDRESS 500 med. art Bldg., Springfield, Mo.	23c. DATE SIGNED Sept. 23, 1952
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9/20/52	24c. NAME OF CEMETERY OR CREMATORY Kisscock Cemetery	24d. LOCATION (City, town, or county) (State) Rhyse, Mo.
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DATE REC'D BY LOCAL REG. 9-24-52	REGISTRAR'S SIGNATURE Ernest Williamson Registrar	25. FUNERAL DIRECTOR'S SIGNATURE Herman H. Lohmeyer	ADDRESS Springfield
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(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 was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Lucien J. Swales

Licensed Embalmer No. 4815

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.