

FILED JUN 1 - 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17256

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 198

1. PLACE OF DEATH a. COUNTY CALLOWAY MO		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY PEPPIE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FULTON MISSOURI		c. CITY OR TOWN SEDALIA	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 10 YRS		e. STREET ADDRESS (If rural, give location) 919 east 6th st	
d. FULL NAME OF HOSPITAL OR INSTITUTION: STATE HOSPITAL NO 1			

3. NAME OF DECEASED (Type or Print) a. (First) ALBERT b. (Middle) KESSLER c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) MAY* 27- 53		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH March- 6th- 1901	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months 2 Days 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) boiler maker		10b. KIND OF BUSINESS OR INDUSTRY railroad shops	11. BIRTHPLACE (City and State or Foreign Country) Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME William Henry Kessler		13b. MOTHER'S MAIDEN NAME Anna Koner		14. NAME OF HUSBAND OR WIFE Mary Kessler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. Not Given		17. INFORMANT'S SIGNATURE OR NAME Hospital Records ADDRESS FULTON MISSOURI	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic nephritis		INTERVAL BETWEEN ONSET AND DEATH long standing
	ANTECEDENT CAUSES Due to (b) syphilitic meningo-encephalitis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 025X		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 11- 47th, to May- 27- 53, that I last saw the deceased alive on May- 26-, 1953, and that death occurred at 9:00P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Henry Fowler M.D.		23b. ADDRESS Fulton Missouri.		23c. DATE SIGNED 5/27/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-26-53		24c. NAME OF CEMETERY OR CREMATORY Crown Hill	
24d. LOCATION (City, town, or county) Sedalia		(State) Mo			

DATE REC'D BY LOCAL REG. May-28-1953		REGISTRAR'S SIGNATURE Maretha Lawrence		25. FUNERAL DIRECTOR'S SIGNATURE M^cLaughlin Bros ADDRESS Sedalia	
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(Licensed Embalmer's Statement on Reverse Side)

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

JUN 8 1953

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 31

P. O. Address Sedal

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license). If embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.