

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29069

State File No. _____

FILED AUG 28 1953

BIRTH NO. 52927 REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 3028 Registrar's No. 165

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carthage</u>		c. LENGTH OF STAY (in this place) <u>9 min.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>rural- McDonald Township</u>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>McCune-Brooks Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>Route 1, Reeds, Mo</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>JERRY</u> b. (Middle) <u>LEE</u> c. (Last) <u>KAHL</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 19-1953</u>		
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>never married</u>	8. DATE OF BIRTH <u>August 19-1953</u>		9. AGE (In years last birthday) <u>8</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>9</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant of Dr. Kahl</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Carthage, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>William H. Kahl</u>		13b. MOTHER'S MAIDEN NAME <u>Dorothy McNary</u>		14. NAME OF HUSBAND OR WIFE <u>---</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Wm Kahl, Rte 1, Reeds, Mo</u>			ADDRESS <u>---</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Birth at about 5 mo gestation.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH
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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) m.		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 8/19, 1953, to 8/19, 1953, that I last saw the deceased alive on 8/19, 1953, and that death occurred at 8 am m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>Carthage, Mo</u>		23c. DATE SIGNED <u>8-20-53</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>8-20-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Avilla Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Avilla, Mo</u>		
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DATE REC'D BY LOCAL REG. <u>8-20-53</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Knell Mortuary, Carthage, Mo</u>	
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(Licensed Embalmer's Signature on Reverse Side)

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

RECEIVED **AUG 27 1953**
Jasper County Health Office
County File Number 700
Date Filed ~~_____~~ **AUG 27 1953**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

Frank W. Keell

Licensed Embalmer No. 4440

P. O. Address Carthage, Mo

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.