

FILED JUL 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24876

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1600

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Arkansas</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give town) <u>AFFTON</u>		c. LENGTH OF STAY (in this place) <u>2 years</u>	c. CITY OR TOWN <u>Corning</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Miller Nursing Home</u>			e. STREET ADDRESS (If rural, give location) <u>Rural Route 803^o 8</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>MALANDIA</u>		b. (Middle) _____	c. (Last) <u>KESTER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>7-12-55</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov ?, 1875</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____
IF UNDER 18 HRS. Hours _____ Min. _____	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>unknown</u>		
13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>James Kester</u>		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>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Wm. Weddle, Box 316, Maryland Hgts</u>			ADDRESS _____	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ 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 _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>334X</u>		21f. HOW DID INJURY OCCUR? _____
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"/>	22. I hereby certify that I attended the deceased from <u>June 2, 1955</u> , to <u>July 12, 1955</u> , that I last saw the deceased alive on <u>July 11, 1955</u> , and that death occurred at <u>6:32 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Melvin R. Wluchki</u> (Degree or title) <u>MD</u>			23b. ADDRESS <u>8916 S. ...</u>		23c. DATE SIGNED <u>7-13-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>7-13-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>UNKNOWN</u>	24d. LOCATION (City, town, or county) (State) <u>Corning, Ark.</u>		
DATE REC'D BY LOCAL REG. <u>7/13/55</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donko MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Russell, Ermert, Corning, Ark.</u> ADDRESS _____			

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 *Ben Hoffman*

Licensed Embalmer No. 45

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.