S. No. 300
v. 10-48

FILED MAR 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4249

BIRTH NO. _____ REG. DIST. NO. 116 PRIMARY REG. DIST. NO. 3020 Registrar's No. 83

1. PLACE OF DEATH
a. COUNTY: Franklin
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington
c. LENGTH OF STAY (in this place): 4 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Francis Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo. b. COUNTY: St Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Augusta Mo 0920
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) ANNA b. (Middle) L c. (Last) KESSLER

4. DATE OF DEATH (Month) (Day) (Year): 2-24-57

5. SEX: F.
6. COLOR OR RACE: White 1
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 1
8. DATE OF BIRTH: Sept. 21-1885
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months 5, Days 3 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Augusta Mo O
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Philip Hilker
13b. MOTHER'S MAIDEN NAME: Koch
14. NAME OF HUSBAND OR WIFE: Oscar 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. ✓
17. INFORMANT'S SIGNATURE OR NAME: Oscar Kessler — ADDRESS: Augusta Mo

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) Acute cardiac decompensation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chr myocarditis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 4222
20. AUTOPSY? YES ☐ NO ☐

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) O

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 24, 1957 *to* Feb 24, 1957 *that I last saw the deceased alive on* Feb 24, 1957 *and that death occurred at* 4:50 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) O: J. P. Lee M.D.
23b. ADDRESS: Washington Mo
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 2-27-57
24c. NAME OF CEMETERY OR CREMATORY: City Cemetery
24d. LOCATION (City, town, or county) (State): Augusta Mo

DATE REC'D BY LOCAL REG.: Feb. 25, 1957
REGISTRAR'S SIGNATURE: F. L. Hindmann G. L. Hindmann
25. FUNERAL DIRECTOR'S SIGNATURE: Olie Thilking — ADDRESS: Augusta Mo

(Licensed Embalmer's Statement on Reverse Side)

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

99

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 Howard O Kessler

Licensed Embalmer No. 4631

P. O. Address Wentzville, 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.