

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31411

STATE FILE NUMBER

FILED OCT 7 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 950-A

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>WEBSTER</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Fordland</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Johns Hospital</b>			Length of stay in lb <b>2 Hours</b>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALBERT B CALSEN</b>				4. DATE OF DEATH <b>OCTOBER 1, 1957</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOVEMBER 22, 1890</b>		
9. AGE (In years last birthday) <b>67</b>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		100. KIND OF BUSINESS OR INDUSTRY		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>				11. BIRTHPLACE (City and state or territory) <b>State of Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>PETER CALSEN</b>				14. MOTHER'S MAIDEN NAME <b>ANNA SUHL</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WORLD WAR I</b>		16. SOCIAL SECURITY NO. <b>491-42-8286</b>		17. INFORMANT <b>MRS. FLOSSIE CALSEN, Fordland, Mo.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage + Edema</b>						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Cerebral Contusion</b>		DUE TO (c) <b>Skull Fracture? 8104</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>27</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>		
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>CAR, TRAIN COLLISION, FORDLAND, MO.</b>						
20c. TIME OF INJURY Hour <b>7:30</b> a. m. Month, Day, Year <b>Oct 1, 1957</b>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>FIRST of Fordland, Mo.</b>		20f. CITY, TOWN, OR LOCATION <b>Fordland, Webster, Mo.</b>		20g. COUNTY <b>WEBSTER</b> STATE <b>MO</b>		
21. I attended the deceased from <b>Oct 1-57</b> to <b>Oct 1-57</b> and last saw her/him alive on <b>Oct 1-57</b> . Death occurred at <b>10:05 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (In full or title) <b>John A. K. Saug</b>				22b. ADDRESS <b>Southwest Medical Bldg. 1636 So. Glenstone</b>		22c. DATE SIGNED <b>10-4-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Oct. 3, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fordland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Fordland, Missouri</b>		
24. FUNERAL DIRECTOR <b>Lynn Jessell, Fordland</b>				25. DATE RECD. BY LOCAL REG. <b>10-4-57</b>		26. REGISTRAR'S SIGNATURE <b>Edith Williams</b>		

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
Oct 3, 1957

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MS SEP 25 1959  
OCT 2 1959  
NOV 1 1959

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 *Wm K Ferrell*.....

Licensed Embalmer No. 491

P. O. Address *Rogersville*

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.