

health, Welfare public service
 300 1-56
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-006124
 STATE FILE NUMBER

FILED FEB 28 1958

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 47

1. PLACE OF DEATH a. COUNTY Jasper				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Lawrence				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage Mo			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Red Oak TWP		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McClune Brooks Hospital 2da			Length of stay in lb	d. STREET ADDRESS Red Oak			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kurt Middle L. wood Last Koontz				4. DATE OF DEATH Month Feb 8 Day 1958				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 6 1957	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 6 Days 2	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Carthage Mo		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Harold L Koontz				14. MOTHER'S MAIDEN NAME Deleta M Schnelle				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Harold L Koontz LaRussell Rtl				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intussusception, ileocecal</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input 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.) 5700					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Carthage Mo			COUNTY Lawrence	STATE Mo
21. I attended the deceased from <u>Feb 7, '58</u> to <u>Feb 8, '58</u> and last saw <u>him</u> alive on <u>Feb 8 '58</u> Death occurred at <u>8:20p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>George A. Wood MD</u> (degree or title)				22b. ADDRESS <u>Carthage Mo</u>		22c. DATE SIGNED <u>Feb 11, '58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 10, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		23d. LOCATION (City, town, or county) <u>Wade Co Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>W.R. Allison</u>			ADDRESS <u>Greenfield Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-18-58</u>		26. REGISTRAR'S SIGNATURE <u>Ely Clinton</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

RECEIVED
Iasper County Health Office
County File Number 58-2-199
Date Filed FEB 26 1958

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 W.R. Allison

Licensed Embalmer No. 440

P. O. Address Greenfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (It is
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.