

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014810  
STATE FILE NUMBER

FILED APR 22 1958

Registration District No. 170 Primary Registration District No. 5631 Registrar's No. 63

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|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Laclede</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Laclede</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Stoutland</b>                   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>Stoutland</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Home in Stoutland</b> |  | Length of stay in 1b<br><b>20 yrs.</b>   | d. STREET ADDRESS (If outside, give location)<br><b>—</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>Henry</b> Last <b>Kail</b>                   |                                  |   | 4. DATE OF DEATH<br>Month <b>4</b> Day <b>8</b> Year <b>1958</b> |  |   |
| 5. SEX<br><b>Male 0</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 30, 1883</b>                          | 9. AGE (In years last birthday)<br><b>74</b> | IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>9</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mail Carrier</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   | 11. BIRTHPLACE (City and state or country)<br><b>Kentucky</b>    | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |

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| 13a. FATHER'S NAME<br><b>Joseph Kail</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Mundy</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Florence J. Kail</b> |
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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)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>499-10-9902</b> | 17. INFORMANT<br>Address<br><b>Clayton D. Briggs, Stoutland, Missouri</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive-arteriosclerotic Heart Disease</b> |                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs.</b>   |
| 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)<br><b>443X</b>                                    |                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/><br><b>None</b> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br><b>—</b> |
| 20c. TIME OF INJURY<br>Hour _____ Month, Day, Year _____ a.m. _____ p.m.   |  |

|   |  |  |                          |                                    |
|---|--|--|--------------------------|------------------------------------|
| 20d. INJURY OCCURRED WHILE AT <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.)<br><b>—</b> | 20f. CITY, TOWN, OR LOCATION<br><b>Lebanon, Mo</b> | COUNTY<br><b>Lebanon</b> | STATE<br><b>Mo</b>                 |
| 21. I attended the deceased from Death occurred at <b>12:20</b> p. <b>2/14/58</b> , to <b>4/10/58</b> and last saw her/him alive on <b>4/10/58</b> on the date stated above; and to the best of my knowledge, from the causes stated. |  |  |                          |                                    |
| 22a. SIGNATURE<br><b>George E. Orsher M.D.</b>  |  | 22b. ADDRESS<br><b>Lebanon, Mo</b>                 |                          | 22c. DATE SIGNED<br><b>4/10/58</b> |

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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>4/10/58</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Stoutland Cemetery</b> | 23d. LOCATION (City, town, or county)<br><b>Stoutland, Laclede, Missouri</b> |
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| 24. FUNERAL DIRECTOR<br><b>Carlos Bledsoe, Lebanon, Mo</b> | ADDRESS<br><b>4-14-1958</b> | 25. DATE RECD. BY LOCAL REG.<br><b>4-14-1958</b> | 26. REGISTRAR'S SIGNATURE<br><b>Hella L. May</b> |
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Received APR 21 1958

Laclede County Health Unit

File No. 63

Date Filed APR 21 1958

APR 24 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 George Staffe

Licensed Embalmer No. 3161

P. O. Address Mr. G. A. S.

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.