

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024253

STATE FILE NUMBER

FILED JUN 16 1958

Registration District No. 324 Primary Registration District No. 6084 Registrar's No. 89

S. 300
v. 1-57

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

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Sedgwick	
b. CITY (If outside county limits, give TOWNSHIP only) OR TOWN Salt Fork Township		c. CITY OR TOWN Wichita	
c. FULL NAME OF DECEASED (If NOT in hospital, give location of HOSPITAL OR INSTITUTION Sweet Springs on Hwy #40)		d. STREET ADDRESS (If outside, give location) 2029 Sante Fe	
3. NAME OF DECEASED (Type or print) First CHARLES Middle WILLIAM Last JESTER		4. DATE OF DEATH June 11, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 43
11. BIRTHPLACE (City and state or country) Avery, Oklahoma		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME James S. Jester		13b. MOTHER'S MAIDEN NAME Laura Ann Morris	
14. NAME OF HUSBAND OR WIFE unknown		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. 447-05-8183		17. INFORMANT Address Frank Jester, Wichita, Kansas	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture base of skull - DUE TO (b) Internal hemorrhage DUE TO (c) Multiple lacerations -			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) Unknown.	
20c. TIME OF INJURY 2 - 6-11-58		20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) Highway 40, 1 1/2 mile S of Salt Fork Twp.		20f. CITY, TOWN, OR LOCATION Salt Fork Twp. COUNTY Saline STATE MO	
21. I attended the deceased from 2:30 - 3:30 am 6-11-58 and last saw her alive on 6-11-58 Death occurred at 2:30 am on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) R. L. Lawrence M.D. (Coroner Saline Co.)		22b. ADDRESS Acres Hall Mo.	
22c. DATE SIGNED 6-11-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE unknown	
23c. NAME OF CEMETERY OR CREMATORY unknown		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR ADDRESS L.F. PARKER SWEET SPRINGS MO		25. DATE RECD. BY LOCAL REG. 6-11-58	
26. REGISTRAR'S SIGNATURE Carl J. Reed			

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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 *L. J. Parker*

Licensed Embalmer No. 3840.....

P. O. Address Sweet Springs, M

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.