

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028813

STATE FILE NUMBER

FILED AUG 25 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 801

5. 300  
7. 1-57

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>Greene</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>Springfield</b> 03960 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>D.O.A. Handley Hosp.</b>		Length of stay in 1b <b>46 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>223 Hayden</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>KATHIL</b> Middle <b>K.</b> Last <b>KARAJOSEPH</b>			4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 26, 1872</b>		9. AGE (In years last birthday) <b>86</b> IF UNDER 1 YEAR: Months <b>8</b> IF UNDER 24 HRS.: Days <b>0</b> Hours <b>0</b> Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Civilian Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	11. BIRTHPLACE (City and state or country) <b>Syria</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>--</b>

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW I</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Mrs. J. W. Baker, Springfield, Mo.</b> Address
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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>Acute Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instat</b> <b>2 days.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary insufficiency</b>	
	DUE TO (c) <b>4201</b>	
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 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.)	
20c. TIME OF INJURY Hour <b>12 noon</b> Month, Day, Year		

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 <b>Springfield, Mo.</b>	COUNTY <b>Greene</b>	STATE <b>Missouri</b>
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21. I attended the deceased from **Aug 13, '58** to **Aug 14, '58** and last saw <sup>her</sup> <sub>him</sub> alive on **Aug 14, '58**  
Death occurred at **12 noon** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Don J. Selsby MD</b>	22b. ADDRESS <b>Springfield, Mo.</b>	22c. DATE SIGNED <b>8/15/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug 19, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>
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24. FUNERAL DIRECTOR <b>Jewell E. Windle</b>	ADDRESS <b>Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-19-58</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related. No symptoms will be listed. No symptoms will be listed. No symptoms will be listed.

SEP 2 1950

ISSUED TO: N  
BY: J. H. ...

DATE OF DEATH: ...  
AGE: ...

PLACE OF DEATH: ...  
CITY: ...  
STATE: ...  
COUNTY: ...

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 *Robert E. Mullman*

Licensed Embalmer No. *4916*  
P. O. Address *Springfield*

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.