

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038709

STATE FILE NUMBER

FILED NOV 7 1958

Registration District No. 379

Primary Registration District No. 45-53

Registrar's No. 37

S. 300  
1-57

3

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>WRIGHT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WRIGHT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MANSFIELD (Union)</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>HARTVILLE</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MANSFIELD</b> Length of stay in lb <b>1 DAY</b>		d. STREET ADDRESS (If outside, give location) <b>1110 5 mi. No.</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <b>WALTER MURTON KESTER</b>			4. DATE OF DEATH Month Day Year <b>10-2-58</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</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>3/5-1877</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>81</b> IF UNDER 1 YEAR Months <b>6</b> Days <b>27</b> IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>1 CEDAR Co., IOWA</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13a. FATHER'S NAME <b>LEUY KESTER</b>		13b. MOTHER'S MAIDEN NAME <b>MARY CATHERINE</b>	14. NAME OF HUSBAND OR WIFE <b>ELTA KESTER</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Hospital Official MANSFIELD, 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>Coronary Occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>One day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>4301</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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 COUNTY STATE
21. I attended the deceased from <b>1953</b> to <b>10-2-58</b> and last saw her alive on <b>10-2-58</b> Death occurred at <b>4:30</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <i>Walter Kester</i>		22b. ADDRESS <b>Mansfield, Missouri</b>	22c. DATE SIGNED <b>10-5-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>10-5-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Steel MEM.</b>	23d. LOCATION (City, town, or county) (State) <b>WRIGHT CO MO</b>
24. FUNERAL DIRECTOR ADDRESS <i>John L. Johnson Hartsville</i>		25. DATE RECD. BY LOCAL REG. <b>10/30/58</b>	26. REGISTRAR'S SIGNATURE <i>Sam Ruck</i>

RECEIVED  
10/6/58  
WRIGHT CO. HEALTH DEPT.  
County File Number 1158/88  
Date Filed 10/6/58

### 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 .....

Licensed Embalmer No.....

P. O. Address .....

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.