

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018880  
STATE FILE NUMBER

FILED MAY 19 1959 Registration District No. 316 Primary Registration District No. — Registrar's No. 197

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>		
b. CITY (If outside corporate limits, give TOWNSHIP) <b>Farmington, Mo. Rural</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			c. CITY OR TOWN <b>St. Louis, Mo.</b> 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>M. neral Area Hosp.</b>		Length of stay in 1b	d. STREET ADDRESS <b>3669 Humphrey</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Jeffrey</b> Middle <b>A.</b> Last <b>Kite</b>			4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1870</b>	9. AGE (In years last birthday) <b>88</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>un-known</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>un-known</b>		13b. MOTHER'S MAIDEN NAME <b>un-known</b>		14. NAME OF HUSBAND OR WIFE <b>Sarah F. Kite</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. C.W. Hensley</b> Address <b>3669 Humphrey St. Louis, 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>Terminal pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Uremic poisoning</b> DUE TO (c) <b>Prostatic hypertrophy</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 to 6 hours</b> <b>One week</b> <b>Several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>610X</b>				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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		STATE
21. I attended the deceased from <b>May 2, 1959</b> to <b>May 5, 1959</b> and last saw him alive on <b>May 5, 1959</b> Death occurred at <b>3:15 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>M.A. Radloff</b> (Sign or title)		22b. ADDRESS <b>Plot Pines Mo</b>	22c. DATE SIGNED <b>5/6/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 7, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rackview</b>	23d. LOCATION (City, town, or county) <b>Farmington, Mo.</b>		
24. FUNERAL DIRECTOR <b>G.H. Cozean</b> ADDRESS <b>Farmington, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>May 12, 1959</b>	26. REGISTRAR'S SIGNATURE <b>G. ether Rudloff</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

vector, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

**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 .....

*Off Cozeman*  
*04084*  
Licensed Embalmer No. ....

*Farmington*  
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.