

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029750

FILED VS SEP 15 1959

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 143

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Macon</u>		Length of stay in 1b <u>7/15.</u>		c. CITY OR TOWN <u>Macon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jefferson St.</u>				d. STREET ADDRESS (If outside, give location) <u>Jefferson St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>David</u> Last <u>Kisor</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>4,</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5/19/1901</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (City and state or country) <u>Linn County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>A. W. Kisor</u>			13b. MOTHER'S MAIDEN NAME <u>Addie Haydon</u>		14. NAME OF HUSBAND OR WIFE <u>no.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>500-16-5793</u>		17. INFORMANT <u>Roy Kisor</u> Address <u>Macon, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive Brain Damage</u> DUE TO (b) <u>32. Cal Pistol</u> DUE TO (c) <u>Suicide</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>Inst.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>Suicide</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour <u>10:45</u> a.m. <u> </u> Month, Day, Year <u>9/4/1959</u>		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.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Macon</u> COUNTY <u>Macon</u> STATE <u>Mo.</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>10:45 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Lester Nutton - Coroner</u>				22b. ADDRESS <u>Macon Mo.</u>		22c. DATE SIGNED <u>9/4/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/8/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Macon, Mo.</u>	
24. FUNERAL DIRECTOR <u>Lester Nutton</u>		ADDRESS <u>Macon, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9/4/59</u>		26. REGISTRAR'S SIGNATURE <u>Cuth McNeely</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles L. Hutton

Licensed Embalmer No. 4577

P. O. Address Macow, Va

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.