

**DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039589**

FILED VS DEC 1 1959

STATE FILE NUMBER

Registration District No. 119 Primary Registration District No. 5436 Registrar's No. 48

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Gasconade</b>	a. STATE <b>Mo</b>		b. COUNTY <b>Gasconade</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Boulware Twp</b>	Length of stay in 1b <b>5 months</b>	c. CITY OR TOWN	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>1 mi. S. W. of Swiss</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> #	d. STREET ADDRESS (If outside, give location) <b>1 mi. S. W. of Swiss</b>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> #

<b>3. NAME OF DECEASED</b> (Type or print)	First <b>LESLIE</b>	Middle <b>JOHN</b>	Last <b>KOHLBUSCH</b>	<b>4. DATE OF DEATH</b>	Month <b>11</b>	Day <b>21</b>	Year <b>1959</b>
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<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Cau.</b>	<b>7. Married</b> # <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>4/23/1890</b>	<b>9. AGE (last birthday)</b> <b>69</b>	<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/>	<b>IF UNDER 24 HR</b> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Tavern Owner</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Tavern (Retired)</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Stony Hill, Mo</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>US</b>
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<b>13a. FATHER'S NAME</b> <b>John Kohlbusch</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Stoeppelmann</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Ella Kohlbusch</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> <b>Birgil J. Kohlbusch, Overland, Mo</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	<b>IMMEDIATE CAUSE (a)</b> <b>Coronary Occlusion</b>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>15 yr</b>
<b>Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last:</b>	<b>DUE TO (b)</b> <b>Diabetes Mellitus</b>	
	<b>DUE TO (c)</b>	

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	COUNTY	STATE
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<b>21. I attended the deceased from</b> <b>Sept. 4, 1958</b> , to <b>Nov. 21, 1959</b> and last saw him alive on <b>Nov. 4, 1959</b> Death occurred at <b>3:30 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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<b>22a. SIGNATURE</b> <i>[Signature]</i>	(Degree or title) <b>D.O.</b>	<b>22b. ADDRESS</b> <b>New Haven Missouri</b>	<b>22c. DATE SIGNED</b> <b>11/22/59</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>11/24/59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Kohlbusch Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>R#1 New Haven, Mo</b>
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<b>24. FUNERAL DIRECTOR</b> <b>Hugo H. Blumer</b>	ADDRESS <b>Hermann, Mo</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>11-22-59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>
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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 me  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Hugo F. Deussen

Licensed Embalmer No. 3160

P. O. Address Hermann, Mo

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.