

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 15 1960

-60-007337

INDEXED

Registration District No. 224 Primary Registration District No. 3046 Registrar's No. 18

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>MONITEAU</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MONITEAU</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CALIFORNIA</u>		Length of stay in 1b		c. CITY OR TOWN <u>CALIFORNIA</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>LATHAM HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle _____ Last <u>KISO</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>2</u> Year <u>1960</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>April-17-1875</u>		9. AGE (last birthday) <u>85</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NO</u>		11. BIRTHPLACE (City and state or country) <u>Osage City Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>JOHN KISO</u>			13b. MOTHER'S MAIDEN NAME _____			14. NAME OF HUSBAND OR WIFE <u>AMANDA BRAHRT KISO</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>487-22-1285</u>		17. INFORMANT <u>Mrs BERTHA LINHARDT</u> Address <u>Ms GIRK 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>CEREBRAL HEMORRHAGE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>FRACTURED NECK OF FEMUR.</u>						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 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 _____ a.m. _____ p.m. _____		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		COUNTY		STATE	
21. I attended the deceased from <u>DEC. 29, 1959</u> to <u>MARCH 2, 1960</u> and last saw him alive on <u>MARCH 2, 1960</u> Death occurred at <u>10 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Loren M. Gallagher M.D.</u> (Degree or title)				22b. ADDRESS <u>California, Mo.</u>			22c. DATE SIGNED <u>3/3/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MAR-4-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LATHAM CEMETERY</u>		23d. LOCATION (City, town, or county) <u>California</u>		STATE <u>Mo</u>		
24. FUNERAL DIRECTOR <u>Hugh E. Williams</u> ADDRESS <u>California Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>3/5/60</u>		26. REGISTRAR'S SIGNATURE <u>Helen L. Papejoy</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 23 1963

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 Russell C. Masq

Licensed Embalmer No. 4804

P. O. Address California

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.