

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035566

FILED VS SEP 19 1960

Registration District No. 234 Primary Registration District No. 5813 Registrar's No. 15

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>MORGAN</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HAW CREEK TWP</u> Length of stay in lb <u>LIFE</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 mi. N.E. STOVER</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MORGAN</u> c. CITY OR TOWN <u>HAW CREEK TWP</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3 mi. N.E. STOVER</u> Residence on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>AUGUST HENRY KERKSIEK</u>			4. DATE OF DEATH Month Day Year <u>SEPT 11 1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 27 1896</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>25</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>FARM</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (City and state or country) <u>STOVER MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WM. KERKSIEK</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH JACOBSON</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</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>NONE</u>		17. INFORMANT <u>WM. KERKSIEK</u> Address <u>STOVER 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>Cerebrovascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Atherosclerosis</u> years DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Grand Mal Epilepsy</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>9-11-60</u> to <u>9-11-60</u> and last saw her/him alive on <u>9-11-60</u> at <u>1:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Do not sign for title) <u>Ray Hyle, M.D.</u>				22b. ADDRESS <u>Stover, Mo.</u>		22c. DATE SIGNED <u>9-13-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>SEPT. 13 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OLD STOVER CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MORGAN COUNTY MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Arnold - Stevinson Stover Mo</u>				25. DATE RECD. BY LOCAL REG. <u>9-16-60</u>		26. REGISTRAR'S SIGNATURE <u>John C. Fippinger</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

James R. Scuman

Licensed Embalmer No. 4880

P. O. Address Verona, N.J.

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.