

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

NOV 9 1960

-60-040679

STATE FILE NUMBER

Registration District No. 319 Primary Registration District No. _____ Registrar's No. 46

1. PLACE OF DEATH a. COUNTY <u>STE. GENEVIEVE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>STE. GENEVIEVE</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JACKSON T.S.</u>		Length of stay in lb <u>25 yrs</u>		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 <u>BLOOMSDALE MO. S.R.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>BLOOMSDALE MO S.R.</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>KUSEL</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>19</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>7/11/85</u>	9. AGE (last birthday) <u>75</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>LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MFG. AMINATIONS</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>DAVID L. KUSEL</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>JULIANN RED</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>498-10-3162</u>		17. INFORMANT <u>Mr Charles Amshutz Bloomdale Mo</u> Address <u>S.R.</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>Generalized cerebral arteriosclerosis 1-2yr.</u>							INTERVAL BETWEEN ONSET AND DEATH	
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) _____						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>2-29-60</u> to <u>10-19-60</u> and last saw him alive on <u>3-22-60</u> Death occurred at <u>7:30 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>J. C. Fairchild, MD</u>				22b. ADDRESS <u>Perryville, Mo.</u>			22c. DATE SIGNED <u>10-22-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10/21/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LEBANON</u>		23d. LOCATION (City, town, or county) (State) <u>STE GENEVIEVE CO. MO</u>			
24. FUNERAL DIRECTOR <u>Doc. Bush Sr. Lebanon Mo</u>			ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>Nov. 2, 1960</u>		26. REGISTRAR'S SIGNATURE _____	

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 Adrian J. Ekler

Licensed Embalmer No. 4740

P. O. Address St. Genevieve

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.