

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041276

FILED VS. DEC 5 1960

53

Registration District No. 3010

Primary Registration District No. 474

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Cape Girardeau</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> COUNTY <i>Cape Girardeau</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Cape Girardeau</i> Length of stay in lb <i>3 weeks</i>		c. CITY OR TOWN <i>Jackson</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <i>Southeast Hospital</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>Greene Ferry Rd.</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>ORA SYLVESTER KINNISON</i>			4. DATE OF DEATH Month Day Year <i>Nov. 25, 1960</i>
5. SEX <i>M</i>	6. COLOR OF RACE <i>white</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>June 11, 1893</i>
9. AGE (last birthday) <i>67</i>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Stock Raising</i>	
11. BIRTHPLACE (City and state or country) <i>Literolle Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Hiram Kinnison</i>		13b. MOTHER'S MAIDEN NAME <i>Elizabeth Hughes</i>	
14. NAME OF HUSBAND OR WIFE <i>Agnes Goodson Kinnison</i>		Address <i>Jackson Mo</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>492-42-1835</i>	
17. INFORMANT <i>Agnes Goodson Kinnison</i>		Address <i>Jackson Mo</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolus</i> DUE TO (b) <i>Complete Rupture of Lower Extremities</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Compression Fracture T5</i>			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 checked="" 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.) <i>Hit in Back</i>	
20c. TIME OF INJURY Hour Month, Day, Year <i>11 4 1960</i> p.m.			
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.) <i>Home</i>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>Jackson Missouri</i>
21. I attended the deceased from <i>11-19-1960</i> to <i>11-25-60</i> and last saw him alive on <i>11-25-60</i> Death occurred at <i>10:35 a.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Michie P. Kasten, M.D.</i>		22b. ADDRESS <i>937 Broadway Cape Girardeau Mo</i>	22c. DATE SIGNED <i>11-30-60</i>
23a. BURIAL, CREMATION, REINTERMENT (Specify) <i>Burial</i>	23b. DATE <i>Nov. 27, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Russell Heights</i>	23d. LOCATION (City, town, or county) (State) <i>Jackson Mo</i>
24. FUNERAL DIRECTOR ADDRESS <i>W. Miller Jackson Mo</i>		25. DATE RECD. BY LOCAL REG. <i>12-1-1960</i>	26. REGISTRAR'S SIGNATURE <i>June Kasten</i>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 13 1930

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

J. C. Invelt

Licensed Embalmer No. 4327

P. O. Address Jackson, N.

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.