

JRI DIVISION OF HEALTH AND WELFARE - STANDARD CERTIFICATE OF DEATH

OFFICE OF PUBLIC HEALTH AND WELFARE

-60-045137

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 694

FILED VS DEC 19 1960

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Columbia</u>		c. CITY OR TOWN <u>Jefferson City</u>	
Length of stay in 1b <u>1 day</u>		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>University Medical Center</u>		d. STREET ADDRESS (If outside, give location) <u>Route 5</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>William</u> Last <u>Kaiser</u>			4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>60</u>			
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-99</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Cole county Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>
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13a. FATHER'S NAME <u>Joseph E Kaiser</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Duke</u>	14. NAME OF HUSBAND OR WIFE <u>Mathilda Kaiser</u>
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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.	17. INFORMANT <u>medical Record</u>	Address
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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>Respiratory Arrest</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>INCREASED CRANIAL Pressure</u>		
DUE TO (c) <u>BRAIN Hemorrhage, metastatic Carcinoma</u>		
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.)
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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
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21. I attended the deceased from 12-13-60 to 12-15-60 and last saw her/him alive on 12-15-60
Death occurred at 1 AM 12-15-60 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph W. [Signature] M.D.</u>	22b. ADDRESS <u>University Hoop College</u>	22c. DATE SIGNED <u>12-15-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>12/17/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Martin</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson City Mo.</u>
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24. FUNERAL DIRECTOR <u>Sylvester Dulle</u>	ADDRESS <u>J.C. Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 15 1960</u>	26. REGISTRAR'S SIGNATURE <u>Thos R E Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 30 1962

SEP 1 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Richard H. Hall*

Licensed Embalmer No. 432

P. O. Address *Jefferson*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.