

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046707

FILED VS JAN 4 1961 383

Registration District No. Primary Registration District No. 5655 Registrar's No. 131

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jasper</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u>		Length of stay in 1b		c. CITY OR TOWN <u>Carthage</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>Mo. State Sanatorium</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>423 Clevenger</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>Aubrey</u> Last <u>Kester</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</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 type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>I-9-16</u>		
9. AGE (last birthday) <u>44</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>Cab Driver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Taxicab</u>		11. BIRTHPLACE (City and state or country) <u>Carthage, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Clarence Kester</u>			13b. MOTHER'S MAIDEN NAME <u>Blanche Keck</u>			14. NAME OF HUSBAND OR WIFE. <u>Divorced</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>490-10-0129</u>		17. INFORMANT Address <u>Mo. STATE SANATORIUM, MT VERNON, 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>Pulmonary Tuberculosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</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.)				
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>I-22-1957</u> to <u>I2-28-1960</u> and last saw him alive on <u>I2-28-1960</u> Death occurred at <u>9:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>md</u>				22b. ADDRESS <u>Mo. State San. Mt. Vernon, Mo.</u>		22c. DATE SIGNED <u>I2-28-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12-29-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Carthage Mo</u>		
24. FUNERAL DIRECTOR <u>Max Z. Forseth</u>		ADDRESS <u>Newton, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-30-60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

Max L. Lonsdale

Licensed Embalmer No. *4252*

P. O. Address *Mukwonago*

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.