

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 688

STATE FILE NUMBER 62-014329

FILED APR 16 1962

1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u>		Length of stay in 1b <u>Few Months</u>	c. CITY OR TOWN <u>Nauvoo</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>Poplar Bluff Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route # 1</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>J.</u> Middle <u>Albert</u> Last <u>Kiedaisch</u>			4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1962</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>2/13/1880</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u>	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>Retired Pharmacist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Pharmacy</u>	11. BIRTHPLACE (City and state or country) <u>Keokuk, Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>John Frederick Kiedaisch</u>	13b. MOTHER'S MAIDEN NAME <u>Madaline Berger</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Maude Kiedaisch</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT Address <u>Mrs. H. M. Henrickson, Poplar Bluff</u>
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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>Cancer of Stomach</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u>2-22-62</u> to <u>3-31-62</u> and last saw him <sup>alive</sup> on <u>March 31, 1962</u> Death occurred at <u>11:00 A. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>Poplar Bluff, Missouri</u>	22c. DATE SIGNED
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23a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>April 1, '62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Keokuk, Iowa</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Frank-Cotrell Chapel, Poplar Bluff, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4/14/1962</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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VS 300  
Rev. 4/59

DATE AMENDED

6/28

28/20

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4 0

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7 1

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9/51X

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11

124-0

131-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Charles E. Mungel

Licensed Embalmer No. 4877

P. O. Address Poplar Bluff MO

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.