

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

■63-042834

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 31 Primary Registration District No. 5106 Registrar's No. 25

FILED DEC 10 1963

1. PLACE OF DEATH a. COUNTY <u>Benton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Benton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Cole Township</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>Cole Camp</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9 Mi. S. Cole Camp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>9 Mi. S. Cole Camp</u>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Margaretha</u> Last <u>Kerksiek</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>4</u> Year <u>1963</u>
5. SEX <u>Female</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>8-26-1880</u>
9. AGE (last birthday) <u>83 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Keeping</u>	11. BIRTHPLACE (City and state or country) <u>Cole Camp, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Heinrich Lackman</u>	
13b. MOTHER'S MAIDEN NAME <u>Margaretha Schroder</u>		14. NAME OF HUSBAND OR WIFE <u>John H. Kerksiek</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>None</u>	17. INFORMANT Address <u>Olaf Kerksiek Cole Camp, Mo. Rt. 2</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>Cerebrovascular Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
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) <u>Fractured Jaw, Due to fall</u>			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 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>Aug. 1963</u> to <u>Dec. 4</u> and last saw her/him alive on <u>Dec. 4, 1963</u> Death occurred at <u>5</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Arthur Gonzalez</u>		22b. ADDRESS <u>Cole Camp, Mo.</u>	22c. DATE SIGNED <u>12-5-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-6-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hulda Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Benton County Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Charles F. Fox Cole Camp, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 5, 1963</u>	26. REGISTRAR'S SIGNATURE <u>E. J. Eichhoff</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

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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 F. Fox

Licensed Embalmer No. 4610

P. O. Address Roll Camp, 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.