

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-048647**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 283

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED DEC 24 1963**

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Cherokee</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		c. CITY OR TOWN <u>Marcus</u>	
Length of stay in 1b <u>10 Years</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>414 Washington St.</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Oscar Kaiser</u>			4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1963</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/94</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grain &amp; Stock</u>		11. BIRTHPLACE (City and state or country) <u>Marcus, Iowa</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Antion Kaiser</u>		13b. MOTHER'S MAIDEN NAME <u>Lillian Staley</u>	
14. NAME OF HUSBAND OR WIFE <u>Effie Kaiser</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWT</u>			
16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT <u>Mrs. Ruby Kaiser, Chillicothe, Mo.</u>			

18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
DUE TO (b) <u>arteriosclerosis</u>		
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>Intestinal Adhesions</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	
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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 1950 to Dec 16-63 and last saw <sup>her</sup> him alive on Dec 1-63  
Death occurred at 10:00 p. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Joseph F. Gale</u> (degree or title)	22b. ADDRESS <u>Chillicothe, Mo</u>	22c. DATE SIGNED <u>12-17-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>19 Dec 63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Marcus Cemetery</u>	23d. LOCATION (City, town, or county) <u>Marcus, Iowa</u>
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24. FUNERAL DIRECTOR <u>Norman Funeral Home, Chillicothe, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 18, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 1 0545  
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MISSOURI

JAN 2 1964

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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 Elton Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, Missouri

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.

Gale