

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**65-041089**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 410

**FILED OCT 26 1965**

VS 300  
Rev. 4/59

1 0940  
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4 1  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Farmington - RURAL</b> Length of stay in lb		c. CITY OR TOWN <b>Doe Run, Mo.</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Thomas Dell Home</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Route #1</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>(Christian Henry Kassabaum</b>			4. DATE OF DEATH Month Day Year <b>Oct. 19 1965</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/1881</b>
9. AGE (last birthday) <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Blacksmith</b>	11. BIRTHPLACE (City and state or country) <b>Mine LaMotte, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Henry Kassabaum</b>	
13b. MOTHER'S MAIDEN NAME <b>Minnie Schmitt</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ear Kassabaum</b>		Address <b>Farmington, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Hypostatic Pressure</b>			<b>2 1/2 hours</b>
DUE TO (b) <b>Thrombosis of cerebral arteries</b>			<b>5 days</b>
DUE TO (c) <b>Arteriosclerosis &amp; Hypotension</b>			<b>unknown</b>
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 checked="" 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 <b>OCT 17 - 1965</b> to <b>OCT 19 - 1965</b> and last saw her/him alive on <b>OCT 19, 1965</b> Death occurred at <b>7:28 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>L.M. Stanfield</b> (Degree of title)		22b. ADDRESS <b>Farmington Mo</b>	22c. DATE SIGNED <b>10/20/65</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 22/1965</b>	23c. NAME OF CEMETERY OR CREMATORY <b>K.of P.</b>	23d. LOCATION (City, town, or county) (State) <b>Farmington Missouri</b>
24. FUNERAL DIRECTOR <b>C.H. Cozean</b> ADDRESS <b>Farmington, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Oct 20, 1965</b>	26. REGISTRAR'S SIGNATURE <b>Gather Rudloff</b>

USE BLACK INK OR TYPEWRITER RIBBON

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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 *W. Cozart*  
Licensed Embalmer No. 40 84

P. O. Address Farmington 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.