

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 23 1949

State File No. 3854

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3854

1. PLACE OF DEATH
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Jackson

b. CITY (If outside corporate limits, write RURAL and give township) Kansas City c. LENGTH OF STAY (in this place) 2 1/2 yrs

c. CITY (If outside corporate limits, write RURAL and give township) Kansas City

d. FULL NAME OF (If not in hospital or institution, give street address or location) K.C. General Hospital No. 1

d. STREET ADDRESS (If rural, give location) 3035 Main St.

3. NAME OF DECEASED
a. (First) Albert b. (Middle) Sterling c. (Last) Kesterson

4. DATE OF DEATH (Month) (Day) (Year) Sept. 6 1949

5. SEX male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower 8. DATE OF BIRTH Dec-5 1860 9. AGE (In years last birthday) 87 8/8 10. UNDER 1 YEAR Months 8 Days 8 11. UNDER 2 HRS. Hours 6 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Picture 10b. KIND OF BUSINESS OR INDUSTRY Bldg. Construction 11. BIRTHPLACE (State or foreign country) Kentucky 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME James R. Kesterson 13b. MOTHER'S MAIDEN NAME Edna J. Graham 14. NAME OF HUSBAND OR WIFE Sarah E. Kesterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. no 17. INFORMANT'S SIGNATURE OR NAME Albert Sterling Kesterson - K.C., Mo. ADDRESS _____

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Postoperative hemorrhage following prostatectomy

ANTECEDENT CAUSES DUE TO (b) Benign Hypertrophy of Prostate

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION W/OX 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR _____

22. I hereby certify that I attended the deceased from 7-26-49 to Sept. 6th 49, that I last saw the deceased alive on 9-8-49, 1949, and that death occurred at 2:25 P.M. from the causes and on the date stated above.

23a. SIGNATURE Wm. W. Hart (Degree or title) _____ 23b. ADDRESS Med. Dir. K.C. Gen. Hospital 23c. DATE SIGNED 9-7-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Sept-8-1949 24c. NAME OF CEMETERY OR CREMATORY Green Lawn 24d. LOCATION (City, town, or county) (State) Kansas City Mo

DATE REC'D BY LOCAL REG. 9-7-49 REGISTRAR'S SIGNATURE Sheldine Holmes 25. FUNERAL DIRECTOR'S SIGNATURE Mrs C R Foster ADDRESS K.C. Mo.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed _____

Joe B. Yoder

Licensed Embalmer No. 4173

P. O. Address K. C. 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 this body is not embalmed, fact should be so stated above.