

Dept. Health,
 & Welfare
 J. S. Public
 Health Service

FILED DEC 31 1957

STANDARD CERTIFICATE OF DEATH

43740
 STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 112

V. S. 300
 Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CARROLL</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CARROLLTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>NORBORNE</u> <u>017</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>WETZEL Hospital</u>		Length of stay in 1b <u>Two weeks</u>	d. STREET ADDRESS (If outside, give location) <u>TWO, ONE HALF MILES EAST</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN CHRIS KRESIN</u>			4. DATE OF DEATH Month Day Year <u>DECEMBER 13, 1957</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 type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 9, 1876</u>	9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. (last birthday) Months Days Hours Min. <u>81</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>URBAINA, ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>WILLIAM KRESIN</u>		13b. MOTHER'S MAIDEN NAME <u>MINNIE STENZEL</u>		14. NAME OF HUSBAND OR WIFE <u>LOUISE KRESIN</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>NO</u>	17. INFORMANT Name Address <u>Kenneth McNish Norborne Mo.</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>Auto Coronary Occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Senility & General debility</u>					<u>years</u>
DUE TO (c) <u>Fracture Neck of Femur</u>					<u>weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Fracture Neck of Femur</u>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. <u>11 30 57</u>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Norborne Carroll Mo</u>	
21. I attended the deceased from Death occurred at <u>8:45 PM</u>		to <u>11-3-57</u> , to <u>12-13-57</u> and last saw her/him alive on <u>12-13-57</u>			
22a. SIGNATURE (Degree or title) <u>Robert Carroll</u>		22b. ADDRESS <u>Carrollton Mo</u>		22c. DATE SIGNED <u>12/13/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>DEC 17-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN. CEM</u>		23d. LOCATION (City, town, or county) (State) <u>NORBORNE MO</u>
24. FUNERAL DIRECTOR <u>DEITCH & SON</u>		ADDRESS <u>NORBORNE MO</u>		25. DATE RECD. BY LOCAL REG. <u>12-19-57</u>	26. REGISTRAR'S SIGNATURE <u>Mr Herbert Calvert</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

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 Ben W. Gibson

Licensed Embalmer No. 2961
P. O. Address Carrollton, 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.