

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030414
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 122

AMENDED

FILED SEP 12 1961

1. PLACE OF DEATH a. COUNTY <u>RAY</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>Richmond TWsp</u>		Length of stay in 1b <u>minutes</u>	c. CITY OR TOWN <u>Norborne</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>5 Mi W Highway 1010</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>304 W 4th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Jeanette Quaintance Kassen</u>			4. DATE OF DEATH Month Day Year <u>Sept. 4th, 1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-27-32</u>	9. AGE (last birthday) <u>28</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Norborne, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Dwight E. Quaintance</u>		13b. MOTHER'S MAIDEN NAME <u>Ruth E. Jones</u>		14. NAME OF HUSBAND OR WIFE <u>John Thomas Kassen</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>unlabeled</u>	17. INFORMANT Address <u>Dr. D.E. Quaintance, Norborne, Mo</u>		

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) <u>Fracture of skull</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Internal injuries</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)			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 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>2 car accident</u>
20c. TIME OF INJURY Hour <u>1</u> Month, Day, Year <u>9-4-61</u> <u>5</u> <u>mike west Richmond, Mo., Hiway 10</u>		
20d. INJURY OCCURRED WHILE AT WORK <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>Hiway 10</u>	20f. PLACE, TOWN, OR LOCATION COUNTY STATE <u>5 mi. w. Richmond, Ray Missouri</u>

21. I attended the deceased from 1:30 to 5 and last saw her/him alive on 9-4-61. Death occurred at 1:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Donuffed Corcoran</u>	22b. ADDRESS <u>Richard, Mo.</u>	22c. DATE SIGNED <u>9-5-61</u>
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-6-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairhaven Cemetery</u>
23d. LOCATION (City, town, or county) <u>Norborne, Mo.</u>		23e. DATE RECD. BY LOCAL REG. <u>9-9-1961</u>
24. FUNERAL DIRECTOR ADDRESS <u>GIBSON FUNERAL HOME Norborne, Mo.</u>		
26. REGISTRAR'S SIGNATURE <u>Mabel Jackson</u>		

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 26 1961

NOV 3 1961

SEP 13 1961

SEP 17 1961

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 James F. Gilson

Licensed Embalmer No. 5076

P. O. Address Camelton,

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.