S. No. 2
1—8-43
5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12885

FILED APR 21 1945

Registration District No. ____ Primary Registration District No. 5133 Registrar's No. 420

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town Rural Marion Twp. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Easton R.2. 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether In this community 71 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town ~~Easton~~ Easton, 11 (If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. #2 (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country ____ 0

3. (a) PRINT FULL NAME William Kessler
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Rose
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Jan (Month) 29 (Day) 1874 (Year)

8. AGE: Years 71 Months 2 Days 20 If less than one day ____ hr. ____ min.

9. Birthplace Buchanan (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business ____

MOTHER FATHER
12. Name Jacob W. Kessler
13. Birthplace ____ (City, town, or county) Mo. (State or foreign country)
14. Maiden name Mollie
15. Birthplace ____ (City, town, or county) Mo. (State or foreign country)

16. (a) Informant F. F. Kessler
(b) Address R.2. Easton, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-45 (Month) (Day) (Year)
(c) Place: burial or cremation Bowen Cem.
18. (a) Signature of funeral director FLEEMAN & SON, INC.
(b) Address ST. JOSEPH, MO.
19. (a) 4-20-45 (Date received local registrar) (b) Helen I. Fickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18 year 1945 hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from Viewed April 18th, 1945 to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Accidental Drowning	
Due to ____	
Due to ____	
Other conditions none (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accidental
(b) Date of occurrence April 18th 1945
(c) Where did injury occur? Rural Buchanan (City or town) (County) Mo, (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? Yes (e) Means of injury drowning

23. Signature R. W. Tadlock (M. D. or other) Coroner
Address King Hill Bldg Date signed 4-20-45

1377

(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~~ .....

....., ~~Registered Apprentice No~~ .....,

working under my personal supervision.

Signed Robert L Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, 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.