

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028288
STATE FILE NUMBER

FILED SEP 8 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 932

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY De Kalb	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Amity
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Methodist Hosp.		Length of stay in lb	326 STREET ADDRESS (If outside, give location)
3. NAME OF DECEASED (Type or print) First Middle Last Ada Keeley		4. DATE OF DEATH Month Day Year 8 28 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-5-1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Benjamin Thornton	
13b. MOTHER'S MAIDEN NAME Julia Clark		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Sara Tiller Address Amity Mo.
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>cerebral edema</u> DUE TO (b) <u>coma, cause unknown</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) 334X			INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 72 hrs.
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 5/26/58 to 8/28/58 and last saw her ^{her} alive on 8/28/58 Death occurred at 4 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John R. Forgrave		22b. ADDRESS 420 N. 82 nd St. Joplin Mo	22c. DATE SIGNED 9/2/58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	9-3-58	Thornton	Clarksdale Mo
24. GENERAL DIRECTOR John Brown		ADDRESS Maysville Mo	25. DATE RECD. BY LOCAL REG. Sept 3, 1958
		26. REGISTRAR'S SIGNATURE Mrs. Clark Woodell	

All diseases in Part I must be causally related. Dr. John R. Forgrave

MEDICAL CERTIFICATION

OCT 14 1958

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 

Licensed Embalmer No. 3933.....

P. O. Address. Maysville 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.