

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
21319

1. PLACE OF DEATH

County Hawell Registration District No. 384 File No. 58
Township Washburn Primary Registration District No. 4777 Registered No. _____
City Washburn Mo St. _____ Ward _____

2. FULL NAME

Will Franklin Keeling
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Ma 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 28 - 1907

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
21 6 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Ints mo -
(STATE OR COUNTRY)

10. NAME OF FATHER J.G. Keeling

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Shannon Co Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah Keury

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Sumnerville, Mo
(STATE OR COUNTRY)

14. INFORMANT J.G. Keeling
(Address) J Beach Tree, Mo

15. FILED 6-10-29 19 29 W.A. Keurich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/1 19 29

17. _____

I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 10:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Residual Traumatism
by circular saw
12:55M

(duration) _____ yrs. _____ mos. 2 da.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRAICTED Birds Iron Mo.
IF NOT AT PLACE OF DEATH _____

2 DID AN OPERATION PRECEDE DEATH. DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) J.G. Keeling M.D.
(Address) Washburn Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Carinth DATE OF BURIAL 6/11-1929

20. UNDERTAKER McFarland's ADDRESS Washburn Mo

25 1929
444
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WHILE FILLING IN, WITH CAREFUL INTEREST TO A FAVORABLE RECORD.

19x9-17-380
21-11-28

896-120

4.0
28

12

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

6-29
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Howell
Township West Plains
City West Plains

Registration District No. 384
Primary Registration District No. 4227

File No. 3-8
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Will Franklin Keeling

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
(b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED 6-10-29 W. A. Keeling REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-9-29

17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-21319