

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.

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

Do not use this space.

FEB 24 1939

2827

1. PLACE OF DEATH 2
 County Lafayette Registration District No. 461
 Township Livingston Primary Registration District No. 3024
 City Livingston, Mo. St. _____ Ward _____
 2. FULL NAME 1600 Cornelia F Keefer
 (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 Fe 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Keefer
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 29-1866
 7. AGE YEARS 72 MONTHS 5 DAYS 2 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at home
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Livingston, Mo.
 FATHER
 13. NAME John Thompson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Georgia
 MOTHER
 15. MAIDEN NAME Sarah Scott
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lafayette Co. Mo.
 17. INFORMANT (ADDRESS) Mrs Ed Thompson Livingston, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Livingston, Mo DATE Feb. 2 1939
 19. UNDERTAKER (ADDRESS) Winkler Livingston, Mo.
 20. FILED Feb. 6 1939 Delia Sales Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 31 1939
 22. I HEREBY CERTIFY That I attended deceased from about 2 years previous to death, 19____ to 19____
 I last saw her alive on Jan 27 1939 Death is said to have occurred on the date stated above, at 6:55 pm.
 The principal cause of death and related causes of importance were as follows:
Hemorrhage of brain Date of onset _____
 Other contributory causes of importance:
High blood pressure and broken thigh from a fall following first hemorrhage and paraplegia
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19____
 Where did injury occur? at fall in her room (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place
In home about a year after first hemorrhage & paraplegia
 Manner of injury _____
 Nature of injury broken thigh
 24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) J. J. Cooper M. D.
 (Address) Livingston, Mo.

82A1

Dr. J. J. [unclear]

CAUSE OR RECEIVED
M. B. EASLEY, JR.
District Health Officer No. 8,
District File Number
Date Filed

2/9/39

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

2827
Do not use this space.

1. PLACE OF DEATH

(a) County Rafayette Registration District No. 461
 (b) Township _____ Primary Registration District No. 3024
 (c) City Lexington (d) Street No. _____ Registered No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Cornelia F Keeper
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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.
72 5 2

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
Supplemental

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sept. 15, 1937 Kentucky

FATHER
 13. NAME age of brain - completely paralyzed following stroke

MOTHER
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) reg. 12, 1937 Kentucky

15. MAIDEN NAME her thigh - bled hemorrhage

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) on June 18, 1939 Missouri

17. INFORMANT (ADDRESS) second daughter from this death followed Jun 31, 1939

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE R.R.C. 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1 - 31 - 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

He paralytic of Brain
High Blood pressure and swollen thigh from a stroke
 Other contributory causes of importance:
fall following fracture of leg & Paralysis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury _____ related to occupation of deceased? _____

If so, specify _____

(Signed) J. F. Cope _____, M. D.

(Address) Lexington Mo

Local Registrar.

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

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.

