

MAY 21 1940

1161

5281A

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH Perry St Mary's
 (a) County Perry
 (b) City or town Rural
 (c) Name of hospital or institution
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
 In this community
 years, months or days

8. (a) PRINT FULL NAME 460
 8. (b) If veteran, name war
 8. (c) Social Security No.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced
 6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive
 7. Birth date of deceased May 2 1940
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 45 hr. min.

9. Birthplace Perry Co. Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation
 11. Industry or business

MOTHER FATHER
 12. Name Frank J. Keller
 13. Birthplace Perry Co. Missouri
 14. Maiden name Sarah Jane Cash
 15. Birthplace Madison Co. Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank J. Keller
 (b) Address Perryville Mo
 17. (a) Burial (b) Date thereof April 3 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation White Water Cemetery

18. (a) Signature of funeral director Young & Sons
 (b) Address Perryville Mo
 19. (a) 5/2 1940 (b) W. J. Winfield
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Perry
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2
 year 1940 hour 2 minute 15 P. M.

21. I hereby certify that I attended the deceased from May 2nd 1940 to May 2nd 1940
 that I last saw him alive on May 2nd 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
Premature Birth

Due to

Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy

Duration

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)
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
600 While at work? (Specify type of place) Means of injury

23. Signature W. J. Winfield (M. D. or other)
 Address Perryville Mo Date signed

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.

1 X1811

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.