

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

15916
Do not use this space.

1. PLACE OF DEATH
 (a) County Douglas Registration District No. 775
 (b) Township Perry Primary Registration District No. 6070-A Registered No. 36
 (c) City Basett (d) Street No. Bonne Terre Hospital St.
 (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. ds.

2. PRINT FULL NAME Carrie Kelso
 (a) Residence, No. Richwoods, MO. St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 1 1874

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>66</u>	<u>4</u>	<u>18</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Richwoods MO

FATHER

13. NAME William Munderck

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Richwoods MO

MOTHER

15. MAIDEN NAME Sarah Munderck

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Richwoods MO

17. INFORMANT (ADDRESS) Clara Ray Flat River MO

18. BURIAL, CREMATION, OR REMOVAL PLACE Recharged DATE April 21 1940

19. FUNERAL DIRECTOR (ADDRESS) W. Sparks 108 Petoskey

20. FILED April 20, 1940 N. W. Hawkins Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4 / 19 1940

22. I HEREBY CERTIFY, That I attended deceased from 4/17, 1940, to 4/19, 1940.
 I last saw h. e. alive on 4/19, 1940. Death is said to have occurred on the date stated above, at 6:30 p. m.
 The principal cause of death and related causes of importance were as follows:
Pneumonia (RT Chest)
(Streptococcus infection)

Date of onset

Other contributory causes of importance:
Pneumonia

Name of operation Stomach Date of 4/18/40
 What test confirmed diagnosis? Rub. Germ. Was there an autopsy? NO

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 in any way related to occupation of deceased? NO
 If so, specify _____
 (Signed) E. H. Appenberg, M. D.
 (Address) Flat River, MO

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.

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STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
.....L. E.
No.....or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-946
Registrar's No. 36

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 778-

Primary Registration District No. 6020A

1. PLACE OF DEATH:

(a) County San Francisco
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Carrie Helms

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 66 Months 4 Days 18 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

DEATH CERTIFICATION

20. DATE OF DEATH: Month 4 day 19 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Empyema (chest)
Streptococcus infection
Due to Tuberc Pneumonia

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Pneumonia
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature C. H. Appleberry (M. D. or other) _____

Address Flat River Date signed _____

SUPPLEMENTAL

MOTHER FATHER

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

