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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

18991

JUN 13 1940 547
Registration District No. 547

Primary Registration District No. 3079

State File No. _____
Registrar's No. 158

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

1. PLACE OF DEATH:

(a) County. Marion St Elizabeth Hospital
(b) City or town. Hannibal Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St Elizabeth
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 3 hours
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike
(c) City or town Frankford
(If outside city or town limits, write "RURAL")
(d) Street No. 10 miles west of Frankford
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME James Louis Keith 300

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased: March 13 1916
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
29 2 2 hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Mahlom Keith

13. Birthplace Ralls County Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Katie Brown Keith

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

16. (a) Informant Katie Keith

(b) Address Frankford Mo

17. (a) Frankford Mo (b) Date thereof May 17 1940
(Burial, cremation, or reburial) (Month) (Day) (Year)

(c) Place: burial or cremation Fair View Cemetary

18. (a) Signature of funeral director Fields And Son

(b) Address Frankford Mo

19. (a) 5/27/40 (b) H. C. Fisher
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 15 day 15
year 1940 hour 9 minute _____ M.

21. I hereby certify that I attended the deceased from May 17
_____, 1940, _____, 19____;

that I last saw her alive on May 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Branch pneumonia Duration _____

Due to _____

Due to _____

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

Major findings: 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?
480
While at work? _____ (Specify type of place)
(e) Means of injury _____

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

Address Frankford Mo Date signed May 17 1940

PHYSICIAN
Underline the cause to which death should be charged statistically.

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.