

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19287
Registrar's No. 87

Registration District No. 711

Primary Registration District No. 54496

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Dixon
(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 10 Months years, months or days

3. (a) PRINT FULL NAME Francis Joseph Keep 100

8. (b) If veteran, name war _____ 8. (c) Social Security No. 495-14-489

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

6. (b) Name of husband or wife Allie Keep 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased 7 (Month) 12 (Day) 1867 (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>10</u>	<u>8</u>	hr. min.

9. Birthplace Cole County, Missouri (City, town, or county) (State or foreign country) 0

10. Usual occupation Laborer 7

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Keep 9

13. Birthplace Unknown (City, town, or county) (State or foreign country) 1

14. Maiden name Mary Bill (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Mrs. Frank Keep

(b) Address Dixon, Mo.

17. (a) Burial (b) Date thereof 5/22/40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pisgah Cemetery

18. (a) Signature of funeral director Fred H. Gilbert 26

(b) Address Dixon, Mo. 102

19. (a) 5/24 (b) 40 A B Beck (Date, selected local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski
(c) City or town Dixon (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 5 day 20 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 10-20 1940 to 5-20-40, 1940; that I last saw him alive on 5-17- 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Wenema Duration 10 days

Due to _____

Due to _____

Other conditions Arteriosclerosis 7 (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? _____

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

23. Signature C. Miller M.D. (M. D. or other) 1

Address Dixon, Mo Date signed 5-22- 40

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

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 hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

May 20, 1940

Registered Apprentice No.....

working under my personal supervision.

District Health Officer No. 5;

District File Number 640 644

Date Filed 6040

Signed

Fred W. Johnson

Licensed Embalmer No. 2341

P. O. Address Dixon, Mo.

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.

7 6

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **19287**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **711**

Primary Registration District No. **4426**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Pulaski**
(b) City or town **Dixon**
(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 _____ years, months or days)

3. (a) PRINT FULL NAME **Francis Joseph Keep**

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

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

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 **72** Months **10** Days **8** If less than one day hr. 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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **5** day **20** year **1946** hour _____ minute _____ M.

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

Immediate cause of death **sepsis**

Due to **Chronic Nephritis**

Due to _____

Other conditions **arterio sclerosis** (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? _____

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

23. Signature **J. M. Miller** (M. D. or other) _____

Address **Dixon Mo.** Date signed _____

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

SUPPLEMENTAL

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

MOTHER FATHER

S-19287