

Registration District No. 316 Primary Registration District No. 2001

1. PLACE OF DEATH: GREENE
(a) County _____
(b) City or town: SPRINGFIELD
(c) Name of hospital or institution: Springfield Baptist Hospital
(d) Length of stay: _____
In this community _____

3. (a) PRINT FULL NAME: Delia Kellett 430
3. (b) If veteran, name war: No
3. (c) Social Security No.: None

4. Sex: Female 5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Cleve Kellett
6. (c) Age of husband or wife if alive: 55 years
7. Birth date of deceased: April 7 1885

8. AGE: Years 55 Months 2 Days 18
If less than one day _____ hr. _____ min.

9. Birthplace: Boone County Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business _____

12. Name: John Hampton 9
13. Birthplace: Omaha Ark.
(City, town, or county) (State or foreign country)

14. Maiden name: Eliza Scott
15. Birthplace: Unknown Unknown
(City, town, or county) (State or foreign country)

18. (a) Informant: Cleve Kellett
(b) Address: Ridge Dale, Missouri

17. (a) Burial (b) Date thereof: June 27, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Enon, Ark.

18. (a) Signature of funeral director: [Signature]
(b) Address: Harrison Ark.

19. (a) June 27, 1940 W.E. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Taney
(c) City or town: Ridgedale
(d) Street No.: Rural
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: June day: 25
year: 1940 hour: 8 minute: 30 P.M.

21. I hereby certify that I attended the deceased from 6/22/40
19 to 6/25/40
that I last saw her alive on 6/25/40
and that death occurred on the date and hour stated above.

Immediate cause of death: Typhoid
Duration: 10 days

Due to: Tick bite

Due to: 44

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

Major findings: _____
Of operations: _____
Of autopsy: _____
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?
a & l l

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

23. Signature: Guy D. Callaway (M. D. or other): _____
Address: Springfield Mo Date signed: 6/26/40

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

9
3
6

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.

X