

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

LED JUL 12 1940

Registration District No.

566

Primary Registration District No.

5762

Registrar's No.

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town Charleston, Mo.  
(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 46 Years  
(Specify whether years, months or days)  
In this community 46 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Mississippi  
(c) City or town Charleston  
(If outside city or town limits, write "RURAL")  
(d) Street No. Cleveland St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME James Henry Kief 100

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

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

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

7. Birth date of deceased Feb, 8th 1854  
(Month) (Day) (Year)

8. AGE: Years 86 Months 4 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Benton Co, Tenn.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business y 9

12. Name James Kief, 9

13. Birthplace Benton Co, Tenn.  
(City, town, or county) (State or foreign country)

14. Maiden name Betty Mc Neal

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

16. (a) Informant's own signature Mrs John Inman  
(b) Address 610 Lake St, Charleston Mo

17. (a) \_\_\_\_\_ (b) Date thereof 6-16-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director G. A. Simpson  
(b) Address Sikeston, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from June 13, 1940 to June 15, 1940  
that I last saw him alive on June 14, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to Tetnus and Gas Gangrene

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? \_\_\_\_\_

745  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature Paul B. ... (M. D. or other) \_\_\_\_\_  
Address Charleston Mo Date signed 6/16/40

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

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.

22

RECEIVED

District Health Officer No. 2

District File Number 740-1200

Date Filed 7/8/40

**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. 2021

working under my personal supervision.

Signed G. A. Dempster

Licensed Embalmer No. 2021

P. O. Address Sikeston 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **22302**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **566**

Primary Registration District No. **5762**

Registrar's No. \_\_\_\_\_

ROWENA MOORE

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

1. PLACE OF DEATH,  
(a) County Mississippi  
(b) City or town Quincy  
(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 James Henry Kiel  
3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

8. AGE: Years 70 Months 11 Days wid If less than one day hr. min.

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

10. Usual occupation Old Age retiree

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

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

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

20. DATE OF DEATH Month June day 15 year 1940 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 \_\_\_\_\_

Due to setrus and gas  
gangrene  
Due to rupture wound of foot  
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) Accident  
(b) Date of occurrence June 1, 1940

(c) Where did injury occur? Charleston, Miss (Specify type of place)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home, choker yard

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury Mail

23. Signature Paul J. Gause (M. D. or other)

Address Charleston, Miss

SUPPLEMENTARY

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 22302

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 576

Primary Registration District No. 5762

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town Memphis  
(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 James Henry Kiel

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 und

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 86 Months 4 Days 7 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

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

10. Usual occupation Old age assistance

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)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 8-3-40 (b) F. A. Vernon  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Mississippi  
(c) City or town Cleveland St  
(If outside city or town limits write "RURAL")  
(d) Street No. Charleston Mo  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11  
year 1946 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 \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Paul J. Bauer (M. D. or other) \_\_\_\_\_

Address Charleston Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL COPY