

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.

MAILED JUL 27 1940

Registration District No. **6221**

Primary Registration District No. **6221**

Registrar's No. **74**

1. PLACE OF DEATH:

(a) County Wright
 (b) City or town Zastoville Rural Precinct
 (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 2
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Vernon Joe Kelley 40
 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 Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Mar 28 1930
 (Month) (Day) (Year)

8. AGE: Years 10 Months 1 Days 17 If less than one day hr. min.

9. Birthplace Zastoville Mo: 6
 (City, town, or county) (State or foreign country)

10. Usual occupation 0

11. Industry or business _____

MOTHER, FATHER
 12. Name B. W. Kelley
 13. Birthplace Zastoville Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name Beane Hunt
 15. Birthplace Zastoville Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature B. W. Kelley
 (b) Address Zastoville Mo
 17. (a) Burial (b) Date thereof May 17 40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Zion Cem

18. (a) Signature of funeral director Edna C. Holden
 (b) Address Zastoville Mo
 19. (a) 6-30-40 (b) Ella Clayton
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wright
 (c) City or town Zastoville Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. R. F. U #1 North West
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 15 day 15 1940
 year 1940 hour 3:00 minute _____ P.M.

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

Immediate cause of death Paracetitis Duration _____

Due to acute arthritis with acute osteomyelitis
 Due to pyelitis

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?
940 (Specify type of place) _____ (e) Means of injury _____
 While at work? _____ (e) Means of injury _____
 23. Signature W. F. Schlicht (M. D. or other) _____
 Address Wright Mo Date signed 5/15/40

57W

RECEIVED

District Health Officer No. 6;

District File Number 740-2299

Date Filed JUL 8 1940

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 Gene E. Haldren
Licensed Embalmer No. 3865
P. O. Address Hartsville, 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. **23122**
Registrar's No. **74**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **906**

Primary Registration District No. **6721**

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

1. PLACE OF DEATH
(a) County **Wright**
(b) City or town **Wadesboro T.C.**
(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
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Vernon Joe Keller**
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
6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
10 1 17 hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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 (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

20. DATE OF DEATH Month **May** day **15** 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 and that death occurred on the date and hour stated above. Immediate cause of death

Myocarditis
acute arthritis
arthritis enter
retinal nephritis
N.M.D.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Of autopsy
92A1

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) Means of injury

23. Signature **W.F. Lehlich** (M. D. or other)
Address **Niangua** Date signed

SUPPLEMENTARY

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

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