

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24748
Registrar's No. 203

Registration District No. 89

Primary Registration District No. 5131

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Rural
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days _____

3. (a) PRINT FULL NAME MARTHA C. KEELE

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

4. Sex Female 5. Color or race White
6. (b) Name of husband or wife James C. Keele 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 1 1850
(Month) (Day) (Year)

8. AGE: Years 90 Months 1 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown 13. Birthplace Mich (City, town, or county) _____ (State or foreign country)
14. Maiden name Mich 15. Birthplace Mich (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature Lillian Keele

(b) Address Williamsville Mo R#1

17. (a) Burial (b) Date thereof June 7 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Keele care

18. (a) Signature of funeral director N.F. Phelps

(b) Address Caplan Bldg Mo

19. (a) 7-12-40 (b) Choltsinger
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County BUTLER
(c) City or town RURAL
(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 June day 5
year 1940 hour 9 minute 25 P. M.

21. I hereby certify that I attended the deceased from June 1, 1940, to June 5, 1940,
that I last saw her alive on June 1, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Arteriosclerosis 5
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 107W
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? _____
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature J. S. Harwell (M. D. or other) _____
Address Caplan Bldg Mo Date signed 6/2/40

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.

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 A. T. Phelps
Licensed Embalmer No. 3231
P. O. Address Caplan Bldg. No.

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.