

FILED AUG 9 1940

Dr. James

S. No. 2
11-10-39
5-17-39
PI X21492DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 25240
637
Registrar's No.

Registration District No. 318

Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County GREENE
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. John Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution five days
 (Specify whether years, months or days)
 In this community five days
 years, months or days)

3. (a) PRINT FULL NAME Mrs. Essie V. Keith 3003. (b) If veteran, name war no 3. (c) Social Security No. no4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Ray Keith 6. (c) Age of husband or wife if alive 45 years7. Birth date of deceased Dec. 29 1903
(Month) (Day) (Year)8. AGE: Years 36 Months 7 Days 2 If less than one day hr. min.9. Birthplace Corkery Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business

12. Name Ruben Berry13. Birthplace Cole Camp Missouri
(City, town, or county) (State or foreign country)14. Maiden name Sarah Adams15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)16. (a) Informant Ray Keith(b) Address Bennett Springs, Missouri.17. (a) Burial (b) Date thereof Aug. 2 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Lone Rock Cemary Corking No. 981118. (a) Signature of funeral director H. H. Lohmeyer.(b) Address Springfield, Mo.19. (a) Aug 2, 1940 (b) W. E. Handley MD
(Date signed local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
 (c) City, or town Bennett Springs,
 (If outside city or town limits, write "RURAL")
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 July day 31
year 1940 hour 7 minute 45 P. M.21. I hereby certify that I attended the deceased from July 24
19 40 to July 31, 19 40
that I last saw her alive on July 31, 19 40,
and that death occurred on the date and hour stated above.Immediate cause of death Peritonitis DurationDue to Premature Separation of the placenta at 5th month of gestationDue to Interine Hemorrhage
since June 13 1940Other conditions Pregnancy 6th month
(Include pregnancy within 3 months of death)Major findings: with premature separation of placentaOf operations Pregnancy with
premature separation of placenta
Of autopsy infected Peritonitis

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 Joseph D. James (M. D. or other) MDAddress Springfield Mo Date signed 8-2-40

(Licensed Embalmer's Statement on Reverse Side)

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

16
3
6

MOTHER FATHER

1448

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 M. L. Canaday

Licensed Embalmer No. 2434

P. O. Address Springfield, 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.

X

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25240
Registrar's No. 637

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(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 _____ (Specify whether
years, months or days _____)

3. (a) PRINT FULL NAME Essie J. Keith

3. (b) If veteran, name war _____

3. (c) Social Security No.

4. Sex F 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 _____ year

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

8. AGE: Years Months Days 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) 8-12-40 (b) W. E. Handley, M.D.
(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 July day 31 - 40
year _____ 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 Pneumonia Duration _____

Premature Separation of placenta. definite infection had developed from placenta when patient first delivered. no prior abortion on delivery.
Other conditions Signancy
(Include pregnancy within 3 months of death)

Major findings:
Of operations section delivery and hysterectomy 7-26-40
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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

