

Registration District No. 503

Primary Registration District No. 5669

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Winn Parson's Care N. Mo.
 (b) City or town Meadville Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
None
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
 (Specify whether years, months or days) All her life

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LINT
 (c) City or town R 7 D Meadville Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. R 7 D
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME Hannah Effie Kelsey 420

3. (b) If veteran, name war No 8. (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 husband 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Sept 6 1871
 (Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Isaac Shore
 13. Birthplace Pennsylvania
 (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Lavina Hartman
 15. Birthplace Pennsylvania
 (City, town, or county) (State or foreign country)

16. (a) Informant Grant Kelsey
 (b) Address Meadville Mo. R.R.

17. (a) Burial (b) Date thereof Jul 28 40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation meadville cemetery

18. (a) Signature of funeral director Staley Funeral Home
 (b) Address Wheeling Mo

19. (a) 7-27-40 (b) E. A. Wren
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
 year 1940 hour 4:30 minute 9 M.

21. I hereby certify that I attended the deceased from Jan - 1938
 _____, 19____ to July 25, 1940
 that I last saw her alive on July 25, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Multiple sclerosis

Due to _____
 Due to _____
 Other conditions malnutrition
 (Include pregnancy within 3 months of death)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.
 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?
452 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____

23. Signature S. N. Hanson (M. D. or other) MD
 Address Meadville Mo Date signed 7-27-40

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

RECEIVED
District Health Officer No. 14,
District File Number 840-1016
Date Filed AUG 2 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 _____

Frank L. Smiley

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed

Frank L. Smiley

Licensed Embalmer No. _____

470

P. O. Address _____

Wheeling W. Va.

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. 25643
Registrar's No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 503

Primary Registration District No. 5669

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

1. PLACE OF BIRTH:

(a) County Linn
(b) City or town Parsons Creek Sup
(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)

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.

3. (a) PRINT FULL NAME

Hannah Effie Kealey

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years Months Days If less than one day
68 10 20 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month July day 26 year _____ 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 Bunch pneumonia
multiple lacerations

Due to _____

Due to _____

Other conditions malnutrition
(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?

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

