

Registration District No. 318

Primary Registration District No. 2001

1. PLACE OF DEATH
(a) County Springfield
(b) City or town Springfield
(c) Name of hospital or institution Springfield Baptist Hospital
(d) Length of stay: In hospital or institution 3 days
In this community 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town Conway
(d) Street No. R. 4
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME WILLIAM TURNER Keeling
3. (b) If veteran, name war no
3. (c) Social Security No. none

20. DATE OF DEATH: Month Aug day 12
year 1940 hour _____ minute 4:35 P.M.

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Della
6. (c) Age of husband or wife if alive 41 years
7. Birth date of deceased June 21 1880

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on Aug 12, 1940
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>6</u>	<u>21</u>	hr. _____ min. _____

Immediate cause of death
1. Bullet wound liver
2. Hepatitis
Due to 22 rifle wound through abdomen
Due to _____
Other conditions: Hemo-pentosemia
(Include pregnancy within 3 months of death)

9. Birthplace Arkansas (City, town, or county) Ark (State or foreign country)
10. Usual occupation Farmer

11. Industry or business _____
12. Name Thomas Keeling
13. Birthplace Greene Co Mo
14. Maiden name Mary Willhite
15. Birthplace Webster Co Mo

Major findings:
Of operations Abdomen full of blood
Wound in liver
Of autopsy _____

16. (a) Informant's own signature Della Keeling
(b) Address Conway Mo.
17. (a) Removal (b) Date thereof 8-12-40
(c) Place: burial or cremation St Luke
18. (a) Signature of funeral director Geo Rainey
(b) Address Marshall Mo
19. (a) Aug 12, 1940 (b) W. E. Handley MD

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Homicide
(b) Date of occurrence Aug 10 1940
(c) Where did injury occur? Webster Co.
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Farm - 10 miles south of Marshall
While at work? yes (e) Means of injury 22 rifle wound
23. Signature W. E. Handley MD (M. D. or other) _____
Address Conway Greene County Date signed 8/12/40

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.

Rev. 6-17-39
U. S. GOVERNMENT PRINTING OFFICE

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 *Lex Laine*

Licensed Embalmer No. 3312

P. O. Address Marshfield 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.

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