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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED DEC 11

State File No. 20021

Registration District No. 1155 Primary Registration District No. 6065 C Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town ~~Graysboro~~ Kelso Township Rural Graysboro
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R.F.D.F. Illmo, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
In this community 40 years. years, months or days) 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scott

(c) City or town Illmo - Rural
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. #1
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ✓ years.

3. (a) PRINT FULL NAME AMBIE BENNETT KEESSEE

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 GEO. W. KEESSEE

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased 5- (Month) 19- (Day) 80. (Year)

8. AGE: Years 60 Months 5 Days 23 If less than one day hr. min.

9. Birthplace HICO, (City, town, or county) CALLOWAY CO. KY. (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business —

FATHER
12. Name JAMES P. BENNETT
13. Birthplace DOVER, TENN. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name MARY FRANCIS PARRISH
15. Birthplace HICO, CALLOWAY CO. KY. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Eugene R. Ryan
(b) Address Flat River, Mo.

17. (a) BURIED (Burial, cremation, or removal) (b) Date thereof 11- (Month) 15- (Day) 40 (Year)
(c) Place: burial or cremation ILLMO, MO.

18. (a) Signature of funeral director Bisplinghoff & Hobbard
(b) Address Illmo, Mo.

19. (a) N.W. 15-40 (Date received local registrar) (b) N. T. Dorrow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 12 year 1940 hour 7 minute 22 A. M.

21. I hereby certify that I attended the deceased from July, 1940 to Nov, 1940 that I last saw her alive on 11-12, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of the uterus	2 yrs.
Due to	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Fred W. Martin (M. D. or other) D.O.
Address Illmo Date signed 11-13

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2,
District File Number 1240-174
Date Filed 12/4/40

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 Mamie Bergling Hoff

Licensed Embalmer No. 3242

P. O. Address Chaffee Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.