

No. 2  
11-10-39  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41813

FILED JAN 13 1940

Registration District No. 19

Primary Registration District No. 4047

Registrar's No. 30

1. PLACE OF DEATH:

(a) County BOONE

(b) City or town STURGEON  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community ALL OF LIFE  
years, months or days

3. (a) PRINT FULL NAME FANNIE MAY KEITHLEY

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased DEC. 19 - 1865  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>11</u>	<u>18</u>	hr. _____ min. _____

9. Birthplace BOONE Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEKEEPER

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name JOHN C. KEITHLEY

13. Birthplace KY.  
(City, town, or county) (State or foreign country)

14. Maiden name LUCY KATHERINE MAHAN

15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Minnie Wynn

(b) Address STURGEON, Mo.

17. (a) BURIAL (b) Date thereof DEC-8-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Pisgah

18. (a) Signature of funeral director Barnett Boothe

(b) Address Sturgeon, Mo.

19. (a) Dec. 7 1940 (b) B. Boothe  
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County BOONE

(c) City or town STURGEON  
(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 12 day 7  
year 1940 hour 8 minute 45 A. M.

21. I hereby certify that I attended the deceased from about 8 or 9  
months ago, 1940, to 12-7, 1940,  
that I last saw her alive on 12-7, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Gangrene

Due to fall & staying in one position for several months

Due to Bad Thrombosis and Gangrene Sarcolipon.

Other conditions long Anemia  
(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) Accident fall

(b) Date of occurrence April 1 - 1940

(c) Where did injury occur? at Home  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
above c.  
(Specify type of place) (e) Means of injury ✓

23. Signature A. A. Johnson (M. D. or other) ✓  
Address Sturgeon Mo Date signed 12/7/40

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

**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. E. Boothe*

Licensed Embalmer No..... *4087*

P. O. Address..... *Sturgeon, 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.**