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FILED FEB 25 1941 3 3

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 5318

Registrar's No. 346

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Leasburg  
(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 for 30 years or more (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Crawford  
(c) City or town Leasburg Mo. (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. ? 29 years.

8. (a) PRINT FULL NAME

Mary M. McKee

3. (b) If veteran, name war \_\_\_\_\_

8. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race W

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

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

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

7. Birth date of deceased 5 26 1862

(Month)

(Day)

(Year)

8. AGE: 79 Years

Months 4

Days 3

If less than one day

hr. \_\_\_\_\_ min.

9. Birthplace Jefferson Co (City, town, or county)

MO (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name Michael M R Key

13. Birthplace Jefferson Co MO (City, town, or county) (State or foreign country)

14. Maiden name McLain

15. Birthplace Jefferson Co MO (City, town, or county) (State or foreign country)

16. (a) Informant Lizian Nicolson

(b) Address Leasburg Mo.

17. (a) Leasburg (b) Date of 1/25 1941 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Basical

18. (a) Signature of funeral director L. Jones

(b) Address Steelville Mo

19. (a) \_\_\_\_\_ (Date received local registrar)

(b) \_\_\_\_\_ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 28  
year 1941 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from 1-20-1941 to 1-23 1941; that I last saw her alive on 1-23 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death)

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? \_\_\_\_\_

209 (Specify type of place) While at work \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature W. J. Drurn (M. D. or other) D  
Address Leasburg Date signed 1-24

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number 241240

Date Filed \_\_\_\_\_

RECEIVED

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 L. D. Jones  
Not Embalmed, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed L. D. Jones  
Licensed Embalmer No. 2379  
P. O. Address Steelville 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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-2140  
X22859  
MOBILE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 2364

Registration District No. 232

Primary Registration District No. 2318

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Crawford  
(b) City or town Liberty T.P.  
(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 \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Mary m Mc Kee  
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 W  
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 79 Months 4 Days 3 If less than one day \_\_\_\_\_ 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 3-28-41 (b) J E Sanders  
(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 1 day 23  
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 \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature W F Swann (M. D. or other) \_\_\_\_\_

Address Leasburg mo Date signed \_\_\_\_\_

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

SUPPLEMENTARY

