

FILED MAR 17 1941

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

7357

Do not use this space.

1. PLACE OF DEATH

(a) County Johnson Registration District No. 5586
 (b) Township Post Oak Primary Registration District No. 4256 5586 Registered No. 430
 (c) City Lecton, Mo. (d) Street No. 1 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Joseph Nicholas McKeekan

(a) Residence, No. RFD Lecton Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Minnie McKeekan
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 20, 1868
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
73 0 19

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. "
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Windsor, Mo.

FATHER 13. NAME Patric Henry McKeekan
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greenville, Tennessee

MOTHER 15. MAIDEN NAME Susan A. Kendric
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

17. INFORMANT Mrs. Minnie McKeekan (ADDRESS) Lecton, Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Lecton Mo. DATE Feb-9-194119. FUNERAL DIRECTOR R.A. Brauning (ADDRESS) Lecton Mo.20. FILED Mar 4, 1941 Annabel Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 8 - 194122. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1940 to Feb 8 - 1941I last saw him alive on Feb 7, 1941 Death is said to have occurred on the date stated above, at 2:00 A.M.

The principal cause of death and related causes of importance were as follows:

Cancer of Liver
 4/10/8
 Ulcers of Stomach

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) W. J. Little M. D.
 (Address) Lecton Mo.

RECEIVED
District Health Officer No. 81
District File Number
3-6-41
Date Filed

STATEMENT BY LICENSED EMBALMER

I, R. A. Brauning, Licensed Embalmer No. 3377
hereby certify that the body recorded on the reverse side of this certificate was ^{Not} embalmed by Me.

..... L. E.
No. or by Registered Apprentice No.
working under my personal supervision.

Signed R. A. Brauning
Licensed Embalmer No. 3377

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7357

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 430

Primary Registration District No. 5386

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town East Oak 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)

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

Joseph Nicholas McKeehan

3. (b) If veteran name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Jan 20 1965
(Month) (Day) (Year)

8. AGE: Years 73 Months 0 Days 19 If less than one day _____ 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) Nov 10 1941 (b) Annabel Reynolds
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18
year 1941 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) _____ (e) Means of injury _____

23. Signature W. J. Little (M. D. or other) _____

Address Lecton Mo Date signed _____

SUPPLEMENTARY

