DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 9 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10002

Registration District No. _____ Primary Registration District No. 202 Registrar's No. 6

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

1. PLACE OF DEATH:
(a) County: Benton
(b) City or town: Ionia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rest White
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ In this community 6 Mos 7 Days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Benton
(c) City or town: Ionia
(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: Mrs Anna Gesina Keuper
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: Married
6. (b) Name of husband or wife: Wm H Keuper
6. (c) Age of husband or wife if alive: 72 years
7. Birth date of deceased: October (Month) 31 (Day) 1870 (Year)
8. AGE: 70 Years, Months 4, Days 7; If less than one day _____ hr. _____ min.
9. Birthplace: Morgan County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: At Home
11. Industry or business: _____
FATHER 12. Name: Henry Ficken
FATHER 13. Birthplace: Missouri (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Margaret Cordes
MOTHER 15. Birthplace: Hanover (City, town, or county) Germany (State or foreign country)
16. (a) Informant: Wm H Keuper
(b) Address: Ionia Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 12-1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Cole Camp Memorial
18. (a) Signature of funeral director: E L Eichhoff
(b) Address: Cole Camp Mo
19. (a) March 11 (Date received local registrar) (b) Mrs. Amy F. Rhodes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8th year 1941 hour 11 minute 20 M.
21. I hereby certify that I attended the deceased from 11-24-40 Nov 24, 1941, to March 8, 1941; that I last saw her alive on March 8, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	2½ hrs
Basilar fracture of skull.	2½ hrs.
Due to: Essential hypertension	
Fracture result of fall.	
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): Fall as result of stroke
(b) Date of occurrence: March 8, 1941
(c) Where did injury occur? Ionia (City or town) Benton (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? At home (Specify type of place)
While at work? _____ (e) Means of injury: _____
23. Signature: J. D. Bennett (M. D. or other) M.D.
Address: Cole Camp, Mo. Date signed 3-10-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 4-41-633
Date Filed 4-8-41

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 E L Eichhorn

Licensed Embalmer No. 730

P. O. Address Cole Camp 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, fact should be so stated above.

No. 2
-4-41
-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10002

Registration District No. 8 Primary Registration District No. 202 Registrar's No.

1. PLACE OF DEATH:

(a) County Benton

(b) ~~City or town~~ West White TP
(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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mrs Anna Gesina Keuper

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

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

7. Birth date of deceased Oct (Month) 31 (Day) 1870 (Year)

8. AGE:	Years	Months	Days	If less than one day
70		4	7	hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) Mar. 11 (Date received local registrar) (b) Mrs. Amy K. Rhodes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 8
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.

	Duration
Immediate cause of death	
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 J. D. Bennett (M. D. or other)
Address Cole Camp Mo Date signed

SUPPLEMENTARY

(Licensed Embalmer's Statement on Reverse Side)

S-10002

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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.