

No. 2
11-10-39
1-17-39
I 2212

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12224

State File No. _____

APR 9 1941
Registration District No. 821

Primary Registration District No. 4553

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott

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

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

(d) Length of stay: In hospital or institution 1 day
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Larry Wayne Keene

8. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife L

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

7. Birth date of deceased March 2 1941
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 29 If less than one day hr. _____ min. _____

9. Birthplace new modicid County msl.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Leslie Keene

13. Birthplace new modicid ms
(City, town, or county) (State or foreign country)

14. Maiden name Mellie Calless

15. Birthplace new modicid County msl.
(City, town, or county) (State or foreign country)

16. (a) Informant Leslie Keene

(b) Address new modicid, ms

17. (a) burial (b) Date thereof April 1 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation new modicid, ms

18. (a) Signature of funeral director A. G. Richards Jr

(b) Address new modicid, ms

19. (a) 4-5-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State ms (b) County New Modicid

(c) City or town new Modicid
(If outside city or town limit, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31
year 1941 hour 5:30 minute 0 P. M.

21. I hereby certify that I attended the deceased from Mar 30 1941 to Mar 31 1941
that I last saw him alive on Mar 31 1941
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Bacillary Dysentery 2 wks
Due to with symptoms 4 days
Due Infected Milk

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations no.

Of autopsy none

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) none

(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? 742

While at work? _____ (Specify type of place)

Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]

Address Sikeston Date signed 4-7-41

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

RECEIVED

District Health Officer No. 2

District File Number 441-44

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.....

Licensed Embalmer No.....

P. O. Address.....

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.