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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 26 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24417

State File No.

Registration District No. 30

Primary Registration District No. 3003

Registrar's No. 34

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Monett
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
West Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Mary Elizabeth Keehne

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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 alive _____ years

7. Birth date of deceased July 21, 1941
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
hr. 10 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Wm. Henry Keehne, Jr.

13. Birthplace Webster Groves, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Hurst Adams

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

16. (a) Informant Mrs. W. H. Keehne, Sr.,

(b) Address R. F. D. #1, Monett, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23, 1941
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Calvary

18. (a) Signature of funeral director W. M. West

(b) Address Monett Mo

19. (a) 7-22-1941 (Date received local registrar) (b) W. M. West (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry
(c) City or town Monett
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 21st day
year 1941 hour 8:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from 7-21-41
_____ 19 _____ to 7-21-41 19 _____
that I last saw her alive on 7-21-41
and that death occurred on the date and hour stated above.

Immediate cause of death Prolonged and difficult parturition

Due to Distorted pelvis of mother

Due to _____

Other conditions jkd
(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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. M. West (M. D. or other) M. D.

Address Monett, Mo. Date signed 7-23-41

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

5
2
1

665
2

1

0

Duration

C

PHYSICIAN

Underline the cause to which death should be charged statistically.

31 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 841-1396

Date Filed AUG 18 1941

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 Phyllis Kullaway

Licensed Embalmer No. 2066

P. O. Address 2204 J St

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.