

Registration District No. 7167

Primary Registration District No. 6698

Registrar's No. 36

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

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Elcham Twp.
(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 Sarah Ann Keleher

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased Jan. 16 - 1850
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
91 6 22 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas L. Bell

13. Birthplace S. Carolina (City, town, or county) (State or foreign country)

14. Maiden name Nancy Oling

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

16. (a) Informant Margaret Anderson

(b) Address Stella, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-41 (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director Geo. W. Williams

(b) Address Goodman, Mo.

19. (a) _____ (Date received local registrar) (b) 41 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County McDonald

(c) City or town Rural - Elcham Twp. (If outside city or town limits, write "RURAL") 060

(d) Street No. _____ (If rural, give location) 0

(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6
year 41 hour 10 minute AM

21. I hereby certify that I attended the deceased from Aug 5 1941 to Aug 6 1941;
that I last saw her alive on Aug 5 1941
and that death occurred on the date and hour stated above.

Immediate cause of death 2. Enterocolitis

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? _____

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

23. Signature J. R. Edmondson (M. D. or other) 0

Address Stella, Mo Date signed 8/11/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number 941-1471

Date Filed SEP 10 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.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28804

Registration District No. 1167

Primary Registration District No. 5698

Registrar's No. _____

1. PLACE OF DEATH: Mc Donald
 (a) County Mc Donald
 (b) City or town Elkhorn Gap
 (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 Sarah A. Keleher
 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 W

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

7. Birth date of deceased Jan 16 1852
 (Month) (Day) (Year)

8. AGE: Years 91 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) 9-4-41 (b) Ada Collins
 (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 _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month _____ Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her 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 _____

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 _____ (M. D. or other)
 Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Steel

