

SEP 15 1941

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

29222

Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 763  
 (b) Township Chalk Level 2 Primary Registration District No. 6006  
 (c) City Louisy City, Mo. (d) Street No. 1 Registered No. 14  
 (e) Length of residence in city or town where death occurred 29 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Nancy Emma Keller

(a) Residence, No. Louisy City, 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF — O. N. Keller

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 22 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, . hrs. or . min.  
70 8 11

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 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) Near Mt. Fall, Mo. (STATE OR COUNTRY) Henry Co. Missouri

FATHER 13. NAME Jacob Thompson Peel

14. BIRTHPLACE (CITY OR TOWN) Not Given (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Jane Hardin

16. BIRTHPLACE (CITY OR TOWN) Don't Know (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Jola Walker Dodson  
Louisy City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Louisy City Cemetery DATE 8/15/1941

19. FUNERAL DIRECTOR (NAME) H. L. Austin (ADDRESS) Louisy City, Mo.

20. FILED \_\_\_\_\_, 19 \_\_\_\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/3/1941

22. I HEREBY CERTIFY, That I attended deceased from 2-8- 1940, to 8-3- 1941

I last saw her alive on 8-3- 1941. Death is said to have occurred on the date stated above, at 12:30 p.m.

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

Myocarditis, ch  
43d  
Arteriosclerosis  
 Date of onset

Other contributory causes of importance:  
Arteriosclerosis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

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? No  
 If so, specify \_\_\_\_\_  
 (Signed) W. Keller M. D.  
 (Address) Appleton City, Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 x 16609

RECEIVED

District Health Officer No. 7,

District File Number 9-41-6647

Date Filed 9-10-41

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 H. C. Austin

Licensed Embalmer No. 3609

P. O. Address Lowry City, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29222  
Registrar's No. ....

Registration District No. 763

Primary Registration District No. 6006

1. PLACE OF DEATH:

(a) County St. Clair  
(b) City or town Chalk River  
(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 Nancy E. Weller

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

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

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

7. Birth date of deceased Nov 22 1874  
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry of 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Aug 4 '41 (b) Sophia L. Stratton  
(Date received at local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year 1941 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 \_\_\_\_\_

Duration

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? \_\_\_\_\_

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

Signature: \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

