DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 6 1941

Registration District No. 8/3

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29644

Primary Registration District No. 6162

Registrar's No. 248

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

1. PLACE OF DEATH:

(a) County: Vernon

(b) City or town: Rural - Washington Tw
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital #3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 6 days (Specify whether years, months or days)

In this community: 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Webster

(c) City or town: Marshfield
(If outside city or town limits write "RURAL")

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

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

3. (a) PRINT FULL NAME: Catherine Keller

3. (b) If veteran, name war: None

3. (c) Social Security No.: Unknown

4. Sex: Female

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: Feb. (Month) 10 (Day) ? (Year)

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

9. Birthplace: Webster County (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Housekeeper

11. Industry or business: —

MOTHER FATHER

12. Name: Joe Keller

13. Birthplace: Tenn. (City, town, or county) (State or foreign country)

14. Maiden name: Martha Banks

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

16. (a) Informant: Sophia Renner (sister)

(b) Address: Marshfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 13-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Fordland Mo

18. (a) Signature of funeral director: [illegible]

(b) Address: Marshfield Mo.

19. (a) 8-11-41 (Date received by local registrar) (b) Allen V. Hayes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 11 year 1941 hour 12:05 A. M.

21. I hereby certify that I attended the deceased from Aug. 5, 1941, to Aug. 11, 1941; that I last saw h.e.x. alive on Aug. 10, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Degenerative Myocarditis	Years
Due to: Senile Dementia	Years
Due to:	
Other conditions (Include pregnancy within 3 months of death): N.A.	
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: [illegible] (M. D. or other) (M.D.)

Address: Nevada, Mo. Date signed: 8-11-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 9-41-1587
Date Filed 9-4-41

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 Lex Lewis

Licensed Embalmer No. 3312

P. O. Address Marshfield

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.

No. 2B
—8-21-41
I X29288

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. 29644

Registration District No. 815 Primary Registration District No. 6162 Registrar's No.

1. PLACE OF DEATH:

(a) County Vernon

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

(c) Name of hospital or institution: State Hosp #3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) 6 days

In this community

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 Catherine Keller

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb. 10 (Month) 1872 (Day) (Year)

8. AGE: Years 68 Months 6 Days 29 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (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) 8-12-41 (Date received local registrar) (b) Allen U Hays (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 11 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?

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

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY