S. No. 8
— 9-3-42
. 5-17-50
PI

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 7 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

42307

State File No.

Registration District No. 448 Primary Registration District No. 5608 Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Morgan (Union 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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede 53
(c) City or town Morgan 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME MARION ALEXANDER KEESLING

3. (b) If veteran, name war ✓

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Wife Lauvina Keesling

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

7. Birth date of deceased August (Month) 7 (Day) 1876 (Year)

8. AGE: Years 65 Months 4 Days 24 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER
12. Name Wm. Keesling
13. Birthplace Don't Know (City, town, or county) (State or foreign country)
14. Maiden name Betty Mace
15. Birthplace Don't Know (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lydie Drahein
(b) Address Morgan Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Jan. 2 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Morgan Mo.

18. (a) Signature of funeral director W. E. Holman
(b) Address Lebanon Mo.

19. (a) 1-2-42 (Date received local registrar) (b) Grace Price (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31 year 1941 hour 4 minute P.M.

21. I hereby certify that I attended the deceased from 10-2 1941, to 12-31- 1941 that I last saw him alive on 12-28-41 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Tuberculosis ✓ — 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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature O. C. Bumgarner (M. D. or other)
Address Conway Mo. Date signed

407 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

~~District Health Officer No.~~

District File Number 1-4-2-2-2

Date Filed Jan. 5 1942

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

V. S. No. 2B
0M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42 307

Registration District No. 448 Primary Registration District No. 5608 Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Laclede
(b) City or town: Morgan (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 years, months or 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: Marion A. Keesling
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: M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Aug (Month) 7 (Day) 1875 (Year)

8. AGE: Years 65 Months 4 Days 27 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
(a) Chronic Tuberculosis	
Due to Chronic Pulmonary Tuberculosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 131
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: J. C. Bruage (M. D. or other)
Address: Conway, Mo. Date signed 2-4-42

SUPPLEMENTARY