

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7723
Registrar's No. 6

Registration District No. 18427

Primary Registration District No. 1-6-18-A 1018A

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town St. Francois Township (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
State Hospital No. 4 21
(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 WILLIAM KELKER

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male race White 5. Color or race Unknown

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

7. Birth date of deceased. Unknown
(Month) (Day) (Year)

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

65 ? _____ hr. _____ min.

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

10. Usual occupation Unknown

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant State Hospital No. 4 Records

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 2-16-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation State Hosp. Cemetery

18. (a) Signature of funeral director Richard J. Juncal Jones

(b) Address Farmington, Mo.

19. (a) 2-18-42 (b) Byrdie S. Bukhmetter
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Francois 94

(c) City or town Farmington 2
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 13th
year 1942 hour 5 minute 25 P. M.

21. I hereby certify that I attended the deceased from Nov. 11th
19 41 to 2-13-42 19 _____

that I last saw him alive on 2-13-42 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____ (Duration _____)

Senile psychosis (Cerebral softening) (Unknown)

Due to Hypostatic pneumonia 1 da

Due to Arteriosclerotic heart disease

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: none 93d
Of operations _____

Of autopsy yes

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? _____

G. Tivis Graves, Jr. (Specify type of placid) _____
(While awaiting _____)

23. Signature G. TIVIS GRAVES, JR. (M. D. or other) M. D.

Address Farmington, Mo. Date signed _____

RECEIVED
District Health Officer No. 4
District File Number 312-302
Date Recd. 3-11-42

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.....

This body was not embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed Chas. Richardson.....

Licensed Embalmer No. 3167.....

P. O. Address Hampton 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, fact should be so stated above.