

FILED APR 20 1942

Registration District No. 799

Primary Registration District No. 6024 A

Registrar's No. 4

## 1. PLACE OF DEATH:

- (a) County St. Francois  
 (b) City or town Osage, Mo. RANTASIA  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution 1

(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

Mr. William Hardy Keel

## 3. (b) If veteran,

name war \_\_\_\_\_

## 3. (c) Social Security

No. \_\_\_\_\_

## 4. Sex

♂ Color or race W6. (a) Single, widowed, married,  
/ divorced married

## 6. (b) Name of husband or wife

Mrs. Martha L. Keel

## 6. (c) Age of husband or wife if

alive \_\_\_\_\_ years

## 7. Birth date of deceased

January 8 1859  
(Month) (Day) (Year)

## 8. AGE:

Years

Months

Days

If less than one day

82104

hr. min.

## 9. Birthplace

Perryco near St. Mary  
(City, town, or county) (State or foreign country)

## 10. Usual occupation

retired farmer

## 11. Industry or business

## 12. Name

Mr. Fredrick Keel

## 13. Birthplace

unknown  
(City, town, or county) (State or foreign country)

## 14. Maiden name

Elizabeth McWilliams

## 15. Birthplace

unknown  
(City, town, or county) (State or foreign country)

## 16. (a) Informant

Mrs. E. J. Heck - daughter

## (b) Address

Osage, Mo.

## 17. (a)

Burial  
(Burial, cremation, or removal)

## (b) Date thereof

3-7-42  
(Month) (Day) (Year)

## (c) Place: burial or cremation

Salem Chapel cemetery

## 18. (a) Signature of funeral director

Alvin W. [unclear]

## (b) Address

303 Crum St. - St. Louis, Mo.

## 19. (a)

3-7-42  
(Date received local registrar)

## (b)

Byrde S. Bukhmerster  
(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State
- Missouri
- , (b) County
- St. Francois

- (c) City or town
- Osage
- 
- (If outside city or town limits, write "RURAL")

- (d) Street No.
- 303
- 
- (If rural, give location)

- (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- March
- day
- 4
- year
- 1942
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from
- July 18 42
- to
- March 3 1942

that I last saw alive on Mar 3 1942 and that death occurred on the date and hour stated above.

## Immediate cause of death

Chronic myocardiopathy  
Senescent arterial sclerosis

## 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 \_\_\_\_\_

23. Signature
- R. Applegate
- (M.D. or other) \_\_\_\_\_
- 
- Address
- Osage, Mo.
- Date signed
- 3-7-42

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

RECEIVED

District Health Officer No. 4

District File Number 442-40

Date Filed 4-9-42

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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Alvin W. Hood A.B.A.  
Licensed Embalmer No. 2780  
P. O. Address 303 Crane St.

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 118 50

Registration District No. 779

Primary Registration District No. 4024a

Registrar's No.

1. PLACE OF DEATH:

(a) County St Francis

(b) City or town Rural  
(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 William H Keel

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

4. Sex m 5. Color or race white 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 Jan 8 - 1909  
(Month) (Day) (Year)

8. AGE: Years 82 Months 11 Days no 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) 3-7-42 (b) Byrdie Bukhmetel  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County St Francis

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

20. DATE OF DEATH: Month mch Day 14 Year 1949 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death: Cor. myocarditis, Arteriosclerosis

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 11/8

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

SUPPLEMENTARY

MOTHER FATHER

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11850