

FILED SEP 11 1942

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

28100

Do not use this space.

1. PLACE OF DEATH

(a) County St. Francis Registration District No. 316
 (b) Township Berry Primary Registration District No. 3059 Registered No. 45
 (c) City Bonne Terre Mo. (d) Street No. 1
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. / ds. (f) How long in U. S., if of foreign birth? 2 yrs. 1 mos. 1 ds.

2. PRINT FULL NAME

(a) Residence, No. Honored KEAY St. 10
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MO 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF -

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 18, 1942

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 50

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
 9. Industry or business in which work was done, as saw mill, bank, etc. none
 10. Date deceased last worked at this occupation (month and year) none 11. Total time (years) spent in this occupation -

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bonne Terre Mo

FATHER 13. NAME MELVIN A. KEAY
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Elgin Mo

MOTHER 15. MAIDEN NAME Louis Ligg
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warthen Mo

17. INFORMANT (ADDRESS) Mrs. Melvin Keay

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE -

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 8-19- 1942 Byrdie Buchmaster Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 18, 1942

22. I HEREBY CERTIFY, That I attended deceased from Aug 18, 1942, to Aug 18, 1942.
 I last saw him alive on Aug 17, 1942. Death is said to have occurred on the date stated above, at 7:30 A. M.

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

Prematurity Date of onset

Other contributory causes of importance: 159

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? - Date of injury -, 1942

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 Dr. W. R. Taylor M. D.

(Signed) Byrdie Buchmaster (Address) Bonne Terre Mo

1170 (Licensed Embalmer's Statement on Reverse Side)

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!

I X12004 5016-7-20-37

RECEIVED

District Health Officer No. 4
District File Number 942-7191
Date Filed 9-2-42

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
..... L. E.
No. or by, Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No.

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28100
Registrar's No. 45

Registration District No. 316

Primary Registration District No. 3059

1. PLACE OF DEATH:

(a) County St Francois
(b) City or town Bonne Terre
(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) (Specify whether

3. (a) PRINT FULL NAME Unnamed Keay

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 s

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

7. Birth date of deceased Aug 18 1942
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or 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) Burial (b) Date thereof 8-19-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bonne Terre Mo.

18. (a) Signature of funeral director Benham Und. Co.

(b) Address Bonne Terre Mo.

19. (a) 8-19-1942 (b) Byrdie Bukhmaster
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year _____ 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 _____

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

Duration

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 _____

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

MOTHER FATHER

SUPPLEMENTARY

28100