

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

36
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1. PLACE OF DEATH:

(a) County FRANKLIN

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

(c) Name of hospital or institution: FOX CREEK BOLLO SWP
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 36

(c) City or town Gray Summitt (If outside city or town limits, write "RURAL") 0

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

(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME MARGARET E. KEHOE

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased MAY 5 1856
(Month) (Day) (Year)

8. AGE: Years 86 Months 4 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace MO (City, town, or county) (State or foreign country) 0

10. Usual occupation AT HOME

11. Industry or business

MOTHER FATHER { 12. Name JOHN KEHOE

{ 13. Birthplace IRELAND (City, town, or county) (State or foreign country) 4

{ 14. Maiden name UNKNOWN

{ 15. Birthplace IRELAND (City, town, or county) (State or foreign country) 4

16. (a) Informant Presley Bradshaw

(b) Address 3701 Linsell Bg.

17. (a) BURIAL (b) Date thereof 9/19/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM

18. (a) Signature of funeral director P. Muller

(b) Address 5165 Belmar Pl.

19. (a) SEP 18 1942 (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 17th
year 1942 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from 8/1/42 to 9/17/42 19 _____
that I last saw her alive on 9/17/42 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Senility
(arterio-sclerosis)

Due to _____

Due to _____

Other conditions Myocardial Regs + atherosclerosis
(Include pregnancy within 5 months of death)

Major findings: _____

Of operations 162

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 W. Jack (M. D. or other) 2nd

Address Wash. Post Bldg Date signed 9/18/42

I issued this burial permit because I could not tell the man where to go to get this permit. Neither could the city offices or the family.

J. Curry
Statistician

St. Louis, Mo. Health Dep't
Layton Mo.

Assistant Collaborating Epidemiologist
U.S.P.H.S.

MISSOURI DEPARTMENT OF HEALTH
EMERALD ST. N.
ST. LOUIS, MO.
Bureau of Registration
Regional Health District

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.....

Licensed Embalmer No. 3384

P. O. Address St. Louis

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.

STANDARD CERTIFICATE OF DEATH

State File No. 30292

Registration District No. 111

Primary Registration District No. 5426

Registrar's No.

1. PLACE OF DEATH:

(a) County Franklin
(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

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

Margaret E. Kehar

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

May
(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

86

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, 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 Sept

Day 19

Year 1942

Hour _____

Minute _____

M. _____

21. I hereby certify that I attended the deceased from _____

to _____, 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 _____

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)

(b) 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 _____

(M. D. or other) _____

Address _____

Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

