

S. No. 2  
M-9-4-41  
5-17-43  
I 15182

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 14323  
Registrar's No. 293

D APR 28 1943 128  
378

Registration District No. Primary Registration District No. 2000

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

1. PLACE OF DEATH: GREFNE  
(a) County: Springfield Mo  
(b) City or town: Springfield Mo  
(c) Name of hospital or institution: 773 W. Mt Vernon  
(d) Length of stay: In hospital or institution: possibly 15 yrs  
In this community: possibly 15 yrs

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Mo (b) County: Greene 39  
(c) City or town: Springfield Mo  
(d) Street No: 773 W. Mt Vernon  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country: \_\_\_\_\_

3. (a) PRINT FULL NAME: Ott T. Kellerman  
3. (b) If veteran, name war: unknown  
3. (c) Social Security No: No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month: Apr day: 11th year: 1943 hour: 2 minute: 30 a.m.  
21. I hereby certify that I attended the deceased from Jan. 17 '43 to 4-11-'43  
that I last saw him alive on 4-10-'43 and that death occurred on the date and hour stated above.

4. Sex: M 5. Color or race: W  
6. (a) Single, widowed, married, divorced: 9 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 1875 (Month) (Day) (Year)

Immediate cause of death: Coronary Occlusion  
Duration: \_\_\_\_\_

8. AGE: Years: 68 Months: = Days: = If less than one day: hr. min.  
9. Birthplace: Unknown Unknown (City, town, or county) (State or foreign country)

Due to: Arteriosclerosis  
Dye to: \_\_\_\_\_  
Other conditions: Prostatic Hypertrophy (Include pregnancy within 3 months of death)

MOTHER FATHER

10. Usual occupation: None  
11. Industry or business: "  
12. Name: unknown  
13. Birthplace: Unknown Unknown (City, town, or county) (State or foreign country)  
14. Maiden name: Unknown  
15. Birthplace: Unknown Unknown (City, town, or county) (State or foreign country)

Major findings: Of operations: 94a  
Of autopsy: \_\_\_\_\_  
PHYSICIAN: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant: Mrs. Vaughn  
(b) Address: 773 W. Mt Vernon Mo  
17. (a) Burial (b) Date thereof: Apr. 12, 1943 (Month) (Day) (Year)  
(c) Place: burial or cremation: Mt. Hazelwood  
18. (a) Signature of funeral director: W. J. Denny  
(b) Address: 629 W. Walnut  
19. (a) 4-12-43 (b) W. S. Handley (Date received local registrar) (Registrar's signature)

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) (a) Means of injury: \_\_\_\_\_  
23. Signature: \_\_\_\_\_ (City or town) (State) (Date signed) 4-12  
Address: Springfield, Mo.

984

(Licensed Embalmer's Statement on Reverse Side)

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**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.....

P. O. Address.....

**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.**