

17-39
X29484
FILED JUN 10 1943
Registration District No. 10250

Primary Registration District No. 11213

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Illmo mo
(c) Name of hospital or institution:
South Gate Convalescent Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 76 DAYS
(Specify whether years, months or days) 1 day

3. (a) PRINT FULL NAME LEAUR, N. LOUISE KEESEE

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

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

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

7. Birth date of deceased FEB. 29 1930
(Month) (Day) (Year)

8. AGE: Years 13 Months 4 Days — If less than one day hr. _____ min. _____

9. Birthplace GRAY'S POINT MO
(City, town, or county) (State or foreign country)

10. Usual occupation School Girl

11. Industry or business _____

MOTHER FATHER
12. Name WILLIAM M. KEESEE
13. Birthplace ILLMO MO
(City, town, or county) (State or foreign country)
14. Maiden name MARY LINDEMAN
15. Birthplace ANGEL MO
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Frank P. ...
(b) Address Illmo. Mo.

17. (a) Burial (b) Date thereof 6-4-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation LIGHTNER, C. MATARY

18. (a) Signature of funeral director P. P. Bickelhoff
(b) Address Illmo Mo

19. (a) 6-3-43 (b) B. J. Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott ¹⁰⁰
(c) City or town Grays Point ⁰
(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 _____ ⁰

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7
year 1943 (hour) 8-45 minute _____ L M.

21. I hereby certify that I attended the deceased from June 1 1943 to June 7 1943
that I last saw alive on June 7 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Acute nephritis ^{1 mo}
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 S. J. Jones (M. D. or other) _____
Address Illmo Mo Date signed 6-3-43

729

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

JUN 12 1943

RECEIVED

District Health Office No. 2,

District File Number 643-753

Date Filed 6-7-43

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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 330

Primary Registration District No. 6112 B

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Selma
(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 1 da. (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Lernard L. Keesee

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Feb. 2 1930
(Month) (Day) (Year)

8. AGE: Years 13 Months 4 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER { 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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scott
(c) City or town Grays Point
(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 June 1943 year _____
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Acute Nephritis
Chronic Nephritis
Desert fever
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 B. J. Jones (M. D. or other) M.D.
Address Selma Mo Date signed 6-13-43

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

SUPPLEMENTARY

S-19222