

FILED AUG 16 1943 107

Registration District No. **107**

Primary Registration District No. **3019**

Registrar's No. **65**

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Keunell
(c) Name of hospital or institution: Dresnell Hospital
(d) Length of stay: In hospital or institution 8 days
In this community 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dunklin
(c) City or town Keunell (Rural)
(d) Street No. 4 1/2 mi. S.W. of Keunell
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME Martha Jane Roberts

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 W

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

7. Birth date of deceased Feb. 27 1875

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>4</u>	<u>19</u>	_____ hr. _____ min.

9. Birthplace Tennessee

10. Usual occupation Home

11. Industry or business Home

12. Name James S. Whitehead

13. Birthplace Tenn

14. Maiden name Elizabeth Douglass

15. Birthplace Tenn

16. (a) Informant Grace Cowley

(b) Address Freeport, Michigan

17. (a) Burial (b) Date thereof 7-17-43

(c) Place: burial or cremation Oak Ridge Cemetery

18. (a) Signature of funeral director Paul Johnson

(b) Address Keunell, Mo.

19. (a) 7-20-1943 (b) Julia Blankenship

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1943 hour 11 minute a.m.

21. I hereby certify that I attended the deceased from 7-8-43 to 7-16-43 that I last saw her alive on 7-16-43 and that death occurred on the date and hour stated above.

Immediate cause of death Semibity uremia
Due to Toxemia

Due to Severe Pyoderma, Singivite.

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature J. Dresnell (M. D. or other) _____
Address Keunell, Mo. Date signed 7-16-43

Duration years 4 days 7 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No 2,

District File Number 843-1035

Date Filed 8-11-43

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 *[Signature]*.....

Licensed Embalmer No. 2556-.....

P. O. Address Kenett, MO-.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Keosauqua
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Presnell Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Meta J. Poindexter

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 W

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

7. Birth date of deceased 7-27-1915
(Month) (Day) (Year)

8. AGE: Years 58 Months 4 Days 19 If less than one day _____ min.

9. Birthplace Tenn.
(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) _____ (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 Linn
(c) City or town Keosauqua
(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 July, day 16, year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 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 _____

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? _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

28143