

V. S. No. 2
FORM-9-4-41
Rev. 5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28253

State File No.

Registrar's No.

683

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

39
2
6

FILED SEP 10 1943

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Springfield Baptist Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Webster 112
(c) City or town RURAL Finley 0
(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 MARY ELLEN KANEL

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive Dec years
7. Birth date of deceased APRIL 24- 1871
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace unk Ohio 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business John Landon

MOTHER FATHER

12. Name John Landon 0

13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown 0

15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant NORMA MAINES

(b) Address Ava Mo.

17. (a) BURIAL (b) Date thereof Aug 27- 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Seymour Cem

18. (a) Signature of funeral director Nelly Ferrell

(b) Address Seymour Mo.

19. (a) 8-21-43 (b) Dr Westlandly
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 20
year 1943 hour 11:00 minute A.M.

21. I hereby certify that I attended the deceased from Aug 17
1943 to Aug 20 1943
that I last saw him alive on Aug 19
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Gall Bladder

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 46 f

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? _____

While at work _____ (Specify type of place)
23. Signature J. H. Halliday (M. D. or other) MD
Address Springfield Mo. Date signed 8-20-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

954

(Licensed Embalmer's Statement on Reverse Side)

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 H. H. Kelley

Licensed Embalmer No. 3337

P. O. Address Bayman, Me

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.