28483

Form No. 2
Rev. 9-4-41
Rev. 5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 13 1943

Registration District No. 1937 — Primary Registration District No. 6293 — Registrar's No. 157

1. PLACE OF DEATH:

(a) County: Jasper

(b) City or town: Rural — Sherdian Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Two and one miles east of Jasper
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ In this community: 40 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jasper

(c) City or town: Rural
(If outside city or town limits, write "RURAL")

(d) Street No.: Two and one half miles east of Jasper
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country: 0

49 0 0

3. (a) PRINT FULL NAME: Mabel Kerney

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: Married

6. (b) Name of husband or wife: Joy Kerney

6. (c) Age of husband or wife if alive: 59 years

7. Birth date of deceased: May (Month) 15th. (Day) 1890 (Year)

8. AGE: Years 53 | Months 2 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace: Tiffin (City, town, or county) Ohio (State or foreign country)

10. Usual occupation: Housekeeping

11. Industry or business: Housewife

FATHER
12. Name: John Sheldon
13. Birthplace: Tiffin Ohio (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Angeline Cooper
15. Birthplace: Unknown (City, town, or county) Ohio (State or foreign country)

16. (a) Informant: Joy J. Kerney
(b) Address: Jasper, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-15-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Green Lawn Cem.

18. (a) Signature of funeral director: Chas. J. Teeter
(b) Address: Jasper, Mo.

19. (a) Aug. 15 '43 (Date received local registrar) (b) Elizabeth Coughlin (Registrar's signature)

1203

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 12 year 1943 hour 1 minute 15 - a. M.

21. I hereby certify that I attended the deceased from 7-1-1943 to 8-12-1943 that I last saw her alive on 7-20-1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Heart Block Coronary Occlusion	
Due to: Chronic Asthma	20 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death): 9 & a	

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? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: W. H. Knott M.D. (M. D. or other)
Address: Jasper, Mo. Date signed 8/12-43

(Licensed Embalmer's Statement on Reverse Side)

48-8-721

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 Thos. J. Tuter

Licensed Embalmer No. 2566

P. O. Address Jasper 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.

. S. No. 2B
0M—5-43
o I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 13 1943

State File No.

Registration District No. 107 Primary Registration District No. 6293 Registrar's No.

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Rural Sheridan Twp.
(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 years, months or days)
In this community

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 Ethel Kerney

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 53 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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 Aug. day 12 year 1943 hour 6-8 minute A.M.

21. I hereby certify that I attended the deceased from 19 to 19, ;
that I last saw h 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)
(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

SUPPLEMENTARY

28483