

ED NOV 10 1943 73

Registration District No. 73

Primary Registration District No. 3014

State File No. _____
Registrar's No. 73

1. PLACE OF DEATH:
(a) County Clay Liberty
(b) City or town _____
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution all her life (Specify whether years, months or days)

3. (a) PRINT FULL NAME MATTIE L. KELLER
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 widowed
6. (b) Name of husband John David Keller 6. (c) Age of husband or wife if alive 1 years
7. Birth date of deceased September 8 1876
(Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 7 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

MOTHER FATHER
12. Name Geo. Folger
13. Birthplace Clay Co. Mo
14. Maiden name Mary Elizabeth M. Burns
15. Birthplace Clay Co. Mo

16. (a) Informant Mrs. Cora Henderson
(b) Address Green St Liberty Mo
17. (a) Burial (b) Date thereof Oct. 16-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri City Mo
18. (a) Signature of funeral director Chas. Arthur Co
(b) Address Liberty, Mo
19. (a) 10-16-43 (b) Deleu Early
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clay
(c) City or town Liberty
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15 year 1943 hour 2 minute 53 A.M.
21. I hereby certify that I attended the deceased from August 9 1943 to Oct 11 1943
that I last saw her alive on and that death occurred on the date and hour stated above

Immediate cause of death Heart disease Duration _____

Due to _____
Due to _____

Other conditions Multiple fracture
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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) Accident in car
(b) Date of occurrence 9/19/43 12:45
(c) Where did injury occur? Liberty Clay Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Chas. Arthur Co (M.D. or other) _____
Address 100 Maple Bldg. Liberty Mo (City or town) (County) (State)

RECEIVED

District Health Officer No.

District File Number

No. Filed

11-9-43

NOV 17 1943

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

Edgar Archer

Licensed Embalmer No.

3311

P. O. Address

Liberty, Mo

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.

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Clay*
(b) City or town *Liberty*
(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 *Wife*
years, months or days) _____ (Specify whether

3. (a) PRINT FULL NAME *Mattie L. Keller*

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 *Sept. 8*
(Month) (Day) (Year)

8. AGE: Years *67* Months *1* Days _____ If less than one day _____ min.

9. Birthplace _____ (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 _____ (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 _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Oct.* day _____ year *1943* hour _____ minute _____ M.

21. I hereby certify that I examined 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: *Arterio sclerotic heart disease*

Duration

Due to _____

Due to _____

Other conditions: *Multiple fractures*
(Include pregnancy within 3 months of death)

Major findings: *186a*
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) *Accident was contributory*

(b) Date of occurrence *9-19-43*

(c) Where did injury occur? *Liberty, Clay, Mo.*
(City or town) (County) (State)

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

Home.
While at work? _____ (Specify type of place) (e) Means of injury *Fall*

23. Signature *John W. Walker* (M. D. or other) *10-16-43*

Address *830 Areyle Blvd - N.C. Mo.* Date signed _____

Professional Bldg. Liberty Mo.

SUPPLEMENTARY

MOTHER, FATHER

WRITE PLAINLY - USE INK - PRINT NAME - MAKE A SEPARATE FILE CARD

34452