

Surgeon
State File No. *127*

FILED JAN 13 1944
Registration District No. *200*

Primary Registration District No. *17243041*

Registrar's No. *127*

1. PLACE OF DEATH:

(a) County *Macon*

(b) City or town *Macon*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *1*
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *Macon*

(c) City or town *Rural*
(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 _____

3. (a) PRINT FULL NAME *John C. Kelley*

3. (b) If veteran name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* day *13*
year *1943* hour *7:30* minute *P* M.

4. Sex *M* 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 *Mar 4 - 1859*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *Dec 13 1943* to *Dec 13 1943*
that I last saw him alive on *Dec 13 1943*
and that death occurred on the date and hour stated above.

8. AGE: Years *84* Months *9* Days *10*
If less than one day _____ hr. _____ min.

Immediate cause of death *Coronary Occlusion* Duration *sudden*

Due to *Arterio-sclerosis (generalized)* *15 or 20 yrs.*

Due to _____

9. Birthplace *Boone Co Mo*
(City, town, or county) (State or foreign country)

10. Usual occupation *Rated Farmer*

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN *940*

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name *John Kelley*

13. Birthplace *D. K.* *9*
(City, town, or county) (State or foreign country)

14. Maiden name *Sarah Barnes*

15. Birthplace *D. K.* *9*
(City, town, or county) (State or foreign country)

16. (a) Informant *Wm Wilson Houpt*

(b) Address *RR Macon*

17. (a) *burial* (b) Date thereof *12/18/43*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Evon Cemetery*

18. (a) Signature of funeral director *Adolf S. Keyser*

(b) Address *Macon Mo*

19. (a) *1/4/44* (b) *J. D. Finckler*
(Date received local registrar) (Registrar's signature)

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 *J. J. Turner* (M. D. or other) *12-29-43*
Address *Macon Mo.* Date signed *12-29-43*

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

MOTHER {
FATHER {

1537

RECEIVED
District Health Officer No. 10
District File Number 1-44-151
Date Filed JAN 12 1944

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 Orland M. Moore
Licensed Embalmer No. 3414
P. O. Address Macon 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.