No. 3
-13-40
-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

6676

State File No.

FILED MAR 8 1944

Registration District No. 43 Primary Registration District No. 4059 Registrar's No. 63

12
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Neelyville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community Yes 2 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Butler
(c) City or town Neelyville
(If outside city or town limits, write "RURAL")
(d) Street No. x
(If rural, give location)
(e) If foreign born, how long in U. S. A.? x 0 years.

3. (a) PRINT FULL NAME Malisia Keeton
3. (b) If veteran, name war
3. (c) Social Security No. x
4. Sex Female
5. Color or race Black
6. (a) ~~Single~~, widowed, married, divorced 2
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April (Month) 15 (Day) 1878 (Year)

8. AGE: Years 66 Months 2 Days 3 If less than one day hr. min.

9. Birthplace Aberdeene (City, town, or county) Miss 1 (State or foreign country)
10. Usual occupation House Keeper
11. Industry or business x
MOTHER FATHER
12. Name W.M. Watson
13. Birthplace N.C. (City, town, or county) 1 (State or foreign country)
MOTHER
14. Maiden name Jane Watson
15. Birthplace N.C. (City, town, or county) 1 (State or foreign country)
16. (a) Informant Moze Keeton
(b) Address Neelyville Mo.
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Neelyville Colored Cem.
18. (a) Signature of funeral director Minnie Gish
(b) Address Naylor Mo.
19. (a) ~~2-29-44~~ (Date received local registrar) (b) Belle Kirkpatrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 1st year 1944 hour 5 minute a M.
21. I hereby certify that I attended the deceased from x x, 19, to x, 19;
that I last saw h x alive on x, 19 x;
and that death occurred on the date and hour stated above.

Immediate cause of death Did not see her till after she died from information from
Due to her son and Lady attendent who were there when she
Due to died Accute Indigestion
Other conditions Senility
(Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

118.3

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) x
(b) Date of occurrence x
(c) Where did injury occur? x (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? x
(Specify type of place)
While at work? x (e) Means of injury 0

23. Signature F. B. Barr (M. D. or other)
Address Neelyville Date signed

3-1-44 92 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No.
District File Number 34-415
Date Filed 3-3-44

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 Norman W. Gil

Licensed Embalmer No. 3387

P. O. Address Richmond, Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-5-43
X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

MAR 9 19

State File No. _____

Registration District No. 105 Primary Registration District No. 4059 Registrar's No. 63

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

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Neelyville
(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 Malina Keeton

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased April (Month) 25 (Day) 1878 (Year)

8. AGE: Years 66 Months 2 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Mexico (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) 3-11-44 (Date received local registrar) (b) Belle Frame (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7-8-44 year 1944 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 _____ 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

FILED

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