

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

FILED SEP 20 1944
Registration District No. **318**

Primary Registration District No. **1003**

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

10
17
9

1. PLACE OF DEATH:

(a) County St. Louis Mo.

(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 33 days
(Specify whether Do)

In this community Do
years, months or days

3. (a) PRINT FULL NAME LOUIE ABERNATHY KEITH

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased 1-17-1889
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>55</u>	<u>7</u>	<u>26</u>	•

hr. _____ min. _____

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

10. Usual occupation Watch repairer.

MOTHER FATHER

11. Industry or business _____

12. Name J. R. Keith

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

14. Maiden name Clara Wellborn

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

16. (a) Informant Mary Keith

(b) Address Hope Ark

17. (a) Removal (b) Date thereof 9-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hope Arkansas

18. (a) Signature of funeral director Howard P. Rowland

(b) Address 4355 Washington

19. (a) SEP 14 1944 (b) J. F. Bludwick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Hempstead

(c) City or town Hope
(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 Sept. day 13
year 1944 hour 8 minute _____ P. M.

21. I hereby certify that I attended the deceased from August 12 1944, to Sept. 13 1944
that I last saw him alive on Sept. 13 1944
and that death occurred on the date and hour stated above.

Immediate cause of death, Pneumonia, acute, adhesive
Pulmonary infarction, multiple

Due to _____

Due to _____

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

Duration

PHYSICIAN

Major findings:
Of operations _____

Of autopsy Pneumonia, acute, adhesive
Pulmonary infarction, multiple

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? _____

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

23. Signature J. C. Abney (M. D. or other) _____
Address BARNES HOSPITAL Date signed 9/14/44

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 *Howard P. Rowland*

Licensed Embalmer No. *3114*

P. O. Address *Paris, 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.