S. No. 2
M—5-42
. 5-17-39
P I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 22 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30926

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 729

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 238 S. Pollison Str
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 238 S Pollison Str
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Artie Keet
3. (b) If veteran, name war UNK.
3. (c) Social Security No. 497-22-7510
4. Sex Female
5. Color or race Col.
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife UNK.
6. (c) Age of husband or wife if alive Dec. years
7. Birth date of deceased May (Month) UNK. (Day) 1884 (Year)

8. AGE: Years 60 Months 5 Days UNK. If less than one day hr. min.

9. Birthplace UNK. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Grocery Clerk.
11. Industry or business
MOTHER FATHER
12. Name Henry Gray
13. Birthplace UNK. (City, town, or county) Missouri (State or foreign country)
14. Maiden name Sallie Wallace
15. Birthplace UNK. (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Delia Hardrick
(b) Address 238 S. Pollison, Spfd., Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-44 (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Memorial
18. (a) Signature of funeral director W. P. Campbell
(b) Address 867 Washington, Spfd., Mo.
19. (a) 9-8-44 (Date received local registrar) (b) by W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 7th year 1944 hour 4:00 minute P. M.
21. I hereby certify that I attended the deceased from August 28, 1944 to September 7, 1944 that I last saw him alive on September 7, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Ovarian Abscess Rupture — Duration
Due to Septicemia
Due to Peritonitis
Other conditions (Include pregnancy within 3 months of death) None
Major findings: Of operations None
Of autopsy None

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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) None
(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 James B. Clark (M. D. or other) M.D.
Address 716 Benton Date signed Sept. 8, 1944 Spfd., Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 W. P. Campbell

Licensed Embalmer No. 1747

P. O. Address Springfield 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.