

FILED JAN 6 3 1945

Registration District No. _____

Primary Registration District No. **4044**

Registrar's No. **12**

1. PLACE OF DEATH:

(a) County **BOONE**
(b) City or town **STURGEON**
(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 _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **BOONE MO**
(c) City or town **STURGEON**
(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 **ELIZA TOMAS KELLY**
3. (b) If veteran, name war **L**
3. (c) Social Security No. **2**

20. DATE OF DEATH: Month **Nov**, day **28**, year **1944** hour **7** minute **P.** M.

MEDICAL CERTIFICATION

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **BEN F. KELLY** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **JUNE 24 - 1867**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **June 1940** to **Nov 28 1944**
that I last saw him **alive on Nov 28** and that death occurred on the date and hour stated above.
Immediate cause of death _____

8. AGE: Years **77** Months **5** Days **4** If less than one day _____ hr. _____ min.

Duration _____
Due to **Arterial apoplexy**
Hypertension
Due to _____
Other conditions **830**
(Include pregnancy within 3 months of death)

9. Birthplace **BOONE Co. Mo. A**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

PHYSICIAN _____
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____
12. Name **BEN RIGGS**
13. Birthplace **Mo. V**
(City, town, or county) (State or foreign country)
14. Maiden name **Polly ANN BAKER**
15. Birthplace **Mo. A**
(City, town, or county) (State or foreign country)

16. (a) Informant **Margaret O. Kelly**
(b) Address **Sturgeon Mo**
17. (a) **Rural** (b) Date thereof **Nov. 30 - 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **MT. HOPE**

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? _____

18. (a) Signature of funeral director **Barnes & Booth**
(b) Address **Sturgeon Mo**
19. (a) **Nov 29 44** (b) **Mary Montgomery**
(Date received local registrar) (Registrar's signature)

(Specify type of place) _____
While at work _____ (c) Means of injury _____
23. Signature **Dr. J. H. Tomer** (M. D. or other) **Dr.**
Address **Sturgeon Mo** Date signed **29/11/44**

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

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 1-5-45

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 R. E. Booth
Licensed Embalmer No. 4087
P. O. Address Sturgen, 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.