

FILED FEB 16 1945
Registration District No. 14

Primary Registration District No. 5297

1. PLACE OF DEATH:
(a) County C. linton
(b) City or town Reed Holt Jackson
(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 _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County C. linton
(c) City or town Holt Missouri 25
(If outside city or town limits, write "RURAL") 6
(d) Street No. _____ (If rural, give location) 6
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Mary Susan Keas.
3. (b) If veteran, name war _____ 3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan 25 day _____ year 1945 hour 3 minute _____ M.

4. Sex Female 5. Color or race White
6. (a) Name of husband or wife Leonidas B Keas 6. (b) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 23 1858
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10 P.M. January 10 1945 to Jan 25 1945 that I last saw him alive on Jan 24 1945 and that death occurred on the date and hour stated above.

8. AGE: Years 86 Months 11 Days 2 If less than one day _____ hr. _____ min.

Immediate cause of death Cerebral Apoplexy
arterio-sclerosis; very protruded heart
Due to _____

9. Birthplace Clay County Missouri
(City, town, or county) (State or foreign country)

Duration 15 days
Due to _____

10. Usual occupation Housewife

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

11. Industry or business _____

Major findings: Of operations _____

12. Name Abner Porter

Of autopsy _____

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

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

14. Maiden name Susan Dykes

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

16. (a) Informant Lelia B Keas Hunter
(b) Address Holt, Missouri

17. (a) Burial (b) Date thereof Jan 27-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Shiloh, Kearney, Mo
18. (a) Signature of funeral director Leonard Gray
(b) Address Kearney Mo

19. (a) _____ (b) _____
(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 W Webb (M. D. or other) _____
Address Holt, Mo. Date signed 1-25-45

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

5-17-39
0

1-1085

(Licensed Embalmer's Statement on Reverse Side)

Handwritten mark

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..... *Leonard Fry*

Licensed Embalmer No..... *1677*

P. O. Address..... *Kearney 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.

Registration District No. 74

Primary Registration District No. 5297

Registrar's No. 33-8

1. PLACE OF DEATH:
 (a) County Clinton
 (b) City or town Self-Ridgeman
(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)

3. (a) PRINT FULL NAME Mary S. Keas
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 _____

7. Birth date of deceased Feb-23-1906
(Month) (Day) (Year)

8. AGE: Years 86 Months 11 Days _____
If less than one day hr. min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) Mrs. A. C. Hartwig
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month _____ Day _____
 Year _____ Hour _____ Minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him/her alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to _____
 Due to _____

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

Major findings:
 Of operations _____
 Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

5897