No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 16 1945

Registration District No. 6 8

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9415

Primary Registration District No. ~~5-2-6-8~~ 5267

Registrar's No. 5

1. PLACE OF DEATH:
(a) County: Christian
(b) City or town: Chestnut Ridge (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: S. Valley Township (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: 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Christian
(c) City or town: P.O. Chestnut Ridge Mo. (If outside city or town limits, write "RURAL")
(d) Street No. 22 (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Rosie A. Keltner
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: Widow
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Jan. (Month) 23 (Day) 1875 (Year)

8. AGE: Years 70 | Months 1 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace: Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: House Keeper
11. Industry or business: Mrs. Cline
12. FATHER Name: Don't Know
13. FATHER Birthplace: Don't Know (City, town, or county) (State or foreign country)
14. MOTHER Maiden name: Don't Know
15. MOTHER Birthplace: Don't Know (City, town, or county) (State or foreign country)
16. (a) Informant: Glenn Keltner
(b) Address: Chestnut Ridge Mo.
17. (a) Schnybach Cemetery (Burial, cremation, or removal) (b) Date thereof: March 2-45 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~: Schnybach Cemetery
18. (a) Signature of funeral director: T. B. Chaffin
(b) Address: Ozark Mo.
19. (a) 3-5-1945 (Date received local registrar) (b) Mabel Moper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 26 year 1945 hour 12 minute 15 P.M.
21. I hereby certify that I attended the deceased from ____, 1940, to Feb 25, 1945; that I last saw her alive on Feb. 25, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Apoplexy — (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: R. O. Mitchell (M. D. or other) DO
Address: Ozark, Missouri Date signed: 3/3/45

1364

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 345-289
Date Filed MAR 14 1945

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 T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark 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.