

UNITED STATES DEPARTMENT OF THE CENSUS
BUREAU OF THE CENSUS
FILLED MAY 15 1948
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12790
Registrar's No. 100

Registration District No. 38 Primary Registration District No. 3006

10
2
4
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Columbia
(c) Name of hospital or institution: Gatewood Convalescent Home
(d) Length of stay: In hospital or institution 4 weeks
In this community 42 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Columbia
(d) Street No. 117 West Oak St
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME ROBERT KEY
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race 2 Negro 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased about 1903

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.
about 42

9. Birthplace Boone Co Mo

10. Usual occupation mortician

11. Industry or business construction

MOTHER FATHER

12. Name Robert Key

13. Birthplace Boone Co Mo

14. Maiden name Dorothy Coleman

15. Birthplace Boone Co Mo

16. (a) Informant George Key

(b) Address Mc Gredy Missouri

17. (a) Burial (b) Date thereof 4-12-1945

(c) Place: burial or cremation Calloway Cemetery

18. (a) Signature of funeral director Street P. Parker

(b) Address Columbia Missouri

19. (a) 4-15-48 (b) Edna H. Barber

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 10
year 1945 hour 10 PM minute 0 P.M.
21. I hereby certify that I attended the deceased from March
1 1945 to April 10 1945
that I last saw him alive on April 6 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other conditions none

Major findings: Of operations no op

Of autopsy none

Duration 3 mos

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

23. Signature AW Kampshmidt (M. D. or other)

Address Columbia Mo Date signed 4-16-45

1250

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-14-45

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 Stuart D. Parker.....

Licensed Embalmer No. 2900.....

P. O. Address Columbia 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.