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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23491

FILED JUL 17 1945

Registration District No. 2

Primary Registration District No. 1000

State File No. _____
Registrar's No. 738

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan //
(c) City or town General Hospital /
(If outside city or town limits, write "RURAL.") 7
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Lynda Sue Keesaman

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex female 5. Color or race white
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 July 1945
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>3</u>	hr. _____ min.

9. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business _____

12. Name George F. Keesaman

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

14. Maiden name Beulah Fay Waldren

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

16. (a) Informant Kenneth R. Bain

(b) Address St. Joseph, Mo.

17. (a) burial (b) Date thereof 7/13 /45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Neaton B. Bell & Co.

(b) Address 319 South 10th Street

19. (a) 7/10/45 (b) Delen J. Feitel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7
year 1945 hour 11:00 minute 45 a.m.

21. I hereby certify that I attended the deceased from July 4 1945 to July 7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Patent Foramen Ovale
of heart
Due to maldevelopment

Duration 5 days

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? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature B. M. Riley (M.D. or other) _____
Address 6007 King Hill Date signed 6-10-45

(Licensed Embalmer's Statement on Reverse Side)

1277

St Joseph, Mo

B/M
6207 King Hill

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: Frank A. [Signature]
Licensed Embalmer No. 1710
P. O. Address at [Signature]

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 449

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 738

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(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 Lynda S. Keesaman

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 _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased July 2 1952
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or Business _____

MOTHER, FATHER { 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) Helen J. Pickett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 2714 Mary
(If rural, give location)

(e) Citizen of foreign country? no (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____
to _____, 19____

that I last saw him _____ 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 _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

SEP 4 1945

23491