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7-5-17-39
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24272

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 24 1945

Registration District No. 160 Primary Registration District No. 3030 Registrar's No. 196

1. PLACE OF DEATH:
 (a) County Jefferson
 (b) City or town Festus
 (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 Jefferson
 (c) City or town Festus
 (If outside city or town limits, write "RURAL")
 (d) Street No. 414 Moore St
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME John Edward Keyton
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 18
 year 1945 hour 4 minute 00 P. M.
 21. I hereby certify that I attended the deceased from May 18
1945 to May 18, 1945
 that I last saw him alive on May 18, 1945
 and that death occurred on the date and hour stated above.

4. Sex M () 5. Color or race W
 6. (a) Single, widowed, married, divorced S 0
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 5 19 45
 (Month) (Day) (Year)

Immediate cause of death
Hemorrhagic disease of newborn.
 Duration 9 hr.

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	<u>12</u> hr. <u>_____</u> min.

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations _____
 Of autopsy _____

9. Birthplace Festus mo
 (City, town, or county) (State or foreign country)
 10. Usual occupation Infant

11. Industry or business _____
 12. Name Earl Odis Keyton
 13. Birthplace Sparta Ill.
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Elizabeth Walker
 15. Birthplace Cap Girardin mo
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Earl Keyton
 (b) Address Festus mo
 17. (a) Burial (b) Date thereof 5-19-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Rose Lawn Mem. Pk.
 18. (a) Signature of funeral director Frank Thud co.
 (b) Address Festus mo
 19. (a) May 23, 1945 (b) Virginia Williams, Reg.
 (Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
 (c) Means of injury TS
 23. Signature John F. Rutledge (M. D. or other) MD
 Address Crystal City Mo Date signed May 24, 1945

1357

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-21-45

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.....

working under my personal supervision.

Registered Apprentice No.

Not Embalmed
Signed.....

Licensed Embalmer No.

P. O. Address.....

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.