

**FILED** NOV 10 1945  
Registration District No. 2631

Primary Registration District No. 55-965591 Registrar's No. 57

1. PLACE OF DEATH:

(a) County Jefferson  
(b) City or town Hematite  
(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 none (Specify whether  
years, months or days) 15 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson  
(c) City or town Hematite  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William T. McKee

3. (b) If veteran, name war ✓ 3. (c) Social Security No. —

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Priscilla Eide 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased June - 12 - 1857  
(Month) (Day) (Year)

8. AGE: Years 88 Months 4 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farming

11. Industry or business self

12. Name Sarah M. McKee

13. Birthplace Jefferson Co Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name William Wilson

15. Birthplace Jefferson Co Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant A. P. McKee  
(b) Address Route 1 - Grubville

17. (a) burial (b) Date thereof Oct. 30 - 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Route 1 - Grubville

18. (a) Signature of funeral director J. Lee Motherhead  
(b) Address Desoto - Mo.

19. (a) 10/30/45 (b) Marie Harris  
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct, day 28  
year 1945 hour 1 minute 50 A.M.

21. I hereby certify that I attended the deceased from Oct 24, 1945 to Oct 28, 1945  
that I last saw him alive on Oct 27, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia  
Cerebral hemorrhage  
Duration 2-3 days  
4 days

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 \_\_\_\_\_  
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)  
Means of injury \_\_\_\_\_

23. Signature J. P. [Signature] (M. D. or other) Do  
Address Desoto Mo Date signed 10/29/45

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

RECEIVED

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

11-9-45

**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. \_\_\_\_\_

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.**

Registration District No. (16) Primary Registration District No. ( )

1. PLACE OF DEATH:  
(a) County Jefferson  
(b) City or town Atm State Central  
(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 None  
In this community 15 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William J. McKee  
3. (b) If veteran, name war   3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife Brisilla Ede 6. (c) Age of husband or wife if alive 28 years  
7. Birth date of deceased June 12  
(Month) (Day) (Year)

8. AGE: Years 88 Months 4 Days 20 If less than one day hr. min.

9. Birthplace St. Louis, Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Self  
11. Industry or business Self

MOTHER FATHER

12. Name Seth McKee  
13. Birthplace Jefferson, Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name W. Nettie Ann Wilson  
15. Birthplace Jefferson, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant W. A. McKee  
(b) Address Festus, Mo. B. P. 2.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30, 1945  
(Month) (Day) (Year)  
(c) Place: burial or cremation Mount St. Louis

18. (a) Signature of funeral director J. Lee Mothershead  
(b) Address De Soto Mo.

19. (a)   (b)    
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jefferson  
(c) City or town Atm State Central  
(If outside city or town limits, write "RURAL")  
(d) Street No.   (If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country

20. DATE OF DEATH: Month Oct Day 28 Year 1945 Hour   minute   M.

21. I hereby certify that I attended the deceased from Oct 27 to Oct 28, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertotic pneumonia 2 days Cerebral hemorrhage 4 days  
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?

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

23. Signature J. P. Ingle (M. D. or other) D. O.  
Address De Soto Mo. Date signed 10/29/45

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

PERMANENT

34011