

No. 2
8-43
17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

34883

FILED NOV 8 1945

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 356

Primary Registration District No. 4521

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Houston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 2 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Texas 107

(c) City or town Houston 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____ 0.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Minnie Abidia 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 Widowed

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

7. Birth date of deceased JAN 29 1871
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22
year 1945 hour 45 minute a. M.

21. I hereby certify that I attended the deceased from Oct 21 1945 to Oct 22 1945
that I last saw her alive on Oct 21 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Insufficiency 2 yrs
Duration _____

8. AGE: Years 74 Months 8 Days 23
If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

Other conditions _____ 9503
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

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

11. Industry or business _____

Major findings:
Of operations _____

12. Name Thomas WEST

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

Of autopsy _____

14. Maiden name MARIE REESE

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

22. If death was due to external causes, fill in the following:

16. (a) Informant Dr. V. A. Keltner

(b) Address Houston, mo.

(c) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof Oct 24 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Christian County

(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? _____

18. (c) Signature of funeral director Dayton T. Elliott
(Address) Calvert mo

While at work? _____ (e) Means of injury _____

19. (a) 10-26-1945 (b) Mrs. Myrtle Craig
(Date received local registrar) (Registrar's signature)

23. Signature John Edens (M. D. or other) _____
Address Calvert mo Date signed Oct 23 1945

1584

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,
District File Number 1145-407
Date Filed 11.6.45.

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 Gaylord V. Elliott
Licensed Embalmer No. 2252
P. O. Address Chapel Hill

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.