

S. No. 2
DOM-5-43
ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37724**

FILED NOV 17 1945

Registration District No. **1778**

Primary Registration District No. **5630**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Rural Johnson mo
(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 Laclede **53**

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

(d) Street No. Route # 2 Lebanon
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Mary E. Keen

3. (b) If veteran, name war _____

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25
year 1945 hour 10 minute 20 A.M.

21. I hereby certify that I attended the deceased from Sept 22nd
1945 to Sept 25 1945
that I last saw her alive on Sept 24th 1945
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife John Keen

6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased Jan. 7 1869
(Month) (Day) (Year)

Immediate cause of death General Circulatory Collapse

Duration _____

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

76 8 18 hr. min.

Due to General Atherosclerosis

Due to Senile Carcinoma

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: Of operations _____

11. Industry or business _____

Of autopsy 46k

12. Name James Watson

13. Birthplace Laclede Co. mo
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

14. Maiden name Unknown

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

16. (a) Informant John Keen

(b) Address Lebanon mo. R# 2

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

(c) Place: burial or cremation Dodson Cemetery

18. (a) Signature of funeral director W.C. Halman

(b) Address Lebanon mo

19. (a) Oct. 10, 1945 (b) Oran H. Frankenburg
(Date received local registrar) (Registrar's signature)

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 R. Saunders (M.D. or other) D.D.

Address Lebanon mo Date signed 9/27/45

Received

Laclede County Health Unit

File No. 10-45-141

Date Filed 11/15/45

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address. Lebanon, 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.