

FILED MO. DECEMBER 12 1945

Registration District No. 238

Primary Registration District No. 5823

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

1. PLACE OF DEATH: New Madrid

(a) County New Madrid

(b) City or town Rural *New Madrid*

(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 7 Years

In this community 7 Years

(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Rural

(d) Street No. 2 miles west of Matthews, Mo.

(e) Citizen of foreign country? no

If yes, name country _____

3. (a) PRINT FULL NAME Huey Andrew Kelso

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 W

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

7. Birth date of deceased 5 28 1869

(Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 8

If less than one day hr. _____ min. _____

9. Birthplace Itawamba Co., Miss.

(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name Isaac Kelso

13. Birthplace Unknown N.C.

14. Maiden name Unknown

15. Birthplace Unknown

(City, town, or county) (State or foreign country)

16. (a) Informant W.D. Kelso

(b) Address Matthews, Mo.

17. (a) Burial (b) Date thereof 10/8/45

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Matthews, Mo.

18. (a) Signature of funeral director H.W. Albritton

(b) Address Sikeston, Mo.

19. (a) 11-27-45 (b) Nelson L. Jones

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 6

year 1945 hour 5 minute P.M.

21. I hereby certify that I attended the deceased from 9-1- 1945 to _____ 19____

that I last saw him alive on 9-1- 1945

and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Cardiac

Valvular disease

Due to Chronic Bronchectom

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? _____

(Specify type of place)

While at work? _____ (Specify type of place)

Means of injury _____

23. Signature D. C. M. Clew (M. D. or other) _____

Address Sikeston Mo Date signed 10-16-45

RECEIVED

District Health Office No. 2,

District File Number 1245-3401

Date Filed 12-11-45

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

Embalmed

Registered Apprentice No.

working under my personal supervision.

Signed

John Alleton

Licensed Embalmer No. 2941

P. O. Address Sikeston, 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.