

S. No. 2
M-2-43
5-17-39
PI X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41491

State File No. _____

Registrar's No. 230

FILED JAN 11 1946
Registration District No. _____

Primary Registration District No. 3028

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

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCune-Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
In this community 65 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Carthage
(If outside city or town limits, write "RURAL")
(d) Street No. Route 3
(If rural, give location)
(e) Citizen of foreign country? no
If yes, name country _____

3. (a) PRINT FULL NAME Mary Belle McKelvey

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (c) Age of husband or wife if alive --- years
7. Birth date of deceased September 29 1865
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 18
If less than one day hr. _____ min.

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

10. Usual occupation at home

11. Industry or business ----

MOTHER FATHER { 12. Name James Leslie
13. Birthplace Pittsburgh Pennsylvania
(City, town, or county) (State or foreign country)
14. Maiden name Henrietta Bybee
15. Birthplace Shelbina Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Frank McKelvey
(b) Address Route 3, Carthage, Mo.

17. (a) Burial (b) Date thereof Dec 19, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Dudman Cemetery

18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Mo.

19. (a) 12-17-45 (b) P. B. Clinton & O.
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
year 1945 hour 12:25 minute a M.

21. I hereby certify that I attended the deceased from Dec 12, 1945, to Dec 17, 1945, that I last saw him alive on Dec 14, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Valvular Heart Disease
Due to Pneumonia

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)
(c) Means of injury _____
23. Signature H. E. Baker (M. D. or other) _____
Address Carthage Mo Date signed _____

1458 (Licensed Embalmer's Statement on Reverse Side)

12-17-45

45-12-991

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..... *Emm L Kuep*

Licensed Embalmer No. *391*

P. O. Address..... *Carthage*

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. 157 Primary Registration District No. 3028

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Chathage
(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

3. (a) PRINT FULL NAME Mary B. McKelvey
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 29, 1865
(Month) (Day) (Year)

8. AGE: Years 80 Months 30 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to (Bronchial)
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of operations _____
Of autopsy _____

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) (b) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address _____ Date signed 107

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

SUPPLEMENTARY

MOTHER FATHER

41491