S. No. 2
M—2-43
. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 11 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4348

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 17

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Rural Washington Ill
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital # 3 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 yrs & 9 days (Specify whether
In this community 18 yrs & 9 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County McDonald 188
(c) City or town Caverna Mo
(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 BESSIE KEENE

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

4. Sex Fem 1 5. Color or race White 6. (a) Single, widowed, married, divorced Separated Married

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

7. Birth date of deceased July 6 1889 (Month) (Day) (Year)

8. AGE: Years 56 Months 6 Days 9 If less than one day hr. min.

9. Birthplace Not given (City, town, or county) 9 (State or foreign country)

10. Usual occupation 4 Int Knowd

11. Industry or business ✓

FATHER
12. Name Frank Lung
13. Birthplace Mo (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Samantha Williams
15. Birthplace Texas (City, town, or county) 1 (State or foreign country)

16. (a) Informant Hospital records
(b) Address Nevada Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-16 46 (Month) (Day) (Year)
(c) Place: burial or cremation Deeridge Ark

18. (a) Signature of funeral director Fryman Home
(b) Address Nevada Mo

19. (a) 1-31-'46 (Date received local registrar) (b) Kathryn Yancey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jany day 15 year 1946 hour 7 minute 20 p m

21. I hereby certify that I attended the deceased from Jany 14 1946 to Jany 15 1946 that I last saw her alive on Jany 15 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pernicious Anemia	
Due to ✓	
Due to ✓	
Other conditions Epilepsy (Include pregnancy within 3 months of death)	
Major findings: Of operations ✓	
Of autopsy No	

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? (e) Means of injury

23. Signature R. G. Hall M.D. (M. D. or other)
Address Nevada Mo Date signed 1/15/46

251 (Licensed Embalmer's Statement on Reverse Side)

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

3423

RECEIVED
District Health Officer No. 7,
District File Number 1-46-84
Date Filed 2-8-46

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 me

, Registered Apprentice No.

working under my personal supervision.

Signed E. B. Terry

Licensed Embalmer No. 1760

P. O. Address Neosho 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.