

FILED JUN 10 1946Primary Registration District No. **5564**Registrar's No. **3**

1. PLACE OF DEATH:

(a) County **Iron**
 (b) City or town **Minimum**
 (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 **Mable Clara Kelley**

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

4. Sex **fem** / 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **single**

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

7. Birth date of deceased. **April 1 1946**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 2 hr. min. **0**

9. Birthplace **Minimum Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business

MOTHER FATHER { 12. Name **Jasper Kelley**
 13. Birthplace **Annapolis Missouri**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Alice Bess**
 15. Birthplace **Ark.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Jasper Kelley**

(b) Address **Minimum Mo.**

17. (a) **burial** (b) Date thereof **4-2-46**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Minimum Mo.**

18. (a) Signature of funeral director **Norman White & Sons**

(b) Address **Ironton Mo.**

19. (a) **May 6 46** (b) **Mrs Lois Jones**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Iron** **47**
 (c) City or town **Minimum** **3**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **0**
 (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **3** **W**
 year **1946** hour **3** minute **30** A.M.

21. I hereby certify that I attended the deceased from **did not attend** 19..... 19.....
 that I last saw him alive on **4-2-46** 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Enteritis**

Due to **unable to give cause**

Due to.....

Other conditions
 (Include pregnancy, within 3 months of death)

Major findings:
 Of operations..... **W**

Of autopsy..... **190**

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 **0**

23. Signature **E. M. J. Patrick** (M. D. or other)

Address **Chesterfield Mo.** Date signed **4/15/46**

Duration

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

RECEIVED

District Health Officer No. 4.....
District File Number 646-2218.....
Date Filed 6-8-46.....

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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. 112

Primary Registration District No. 5562

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Iron
 (b) City or town Miner
 (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

Mable C. Kelley
 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 5

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

7. Birth date of deceased Apr. (Month) 5 (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ 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) May 3-16 (b) Mrs. A. Jones
 (Date received local registrar) (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 _____

Duration _____

Due to _____

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 _____

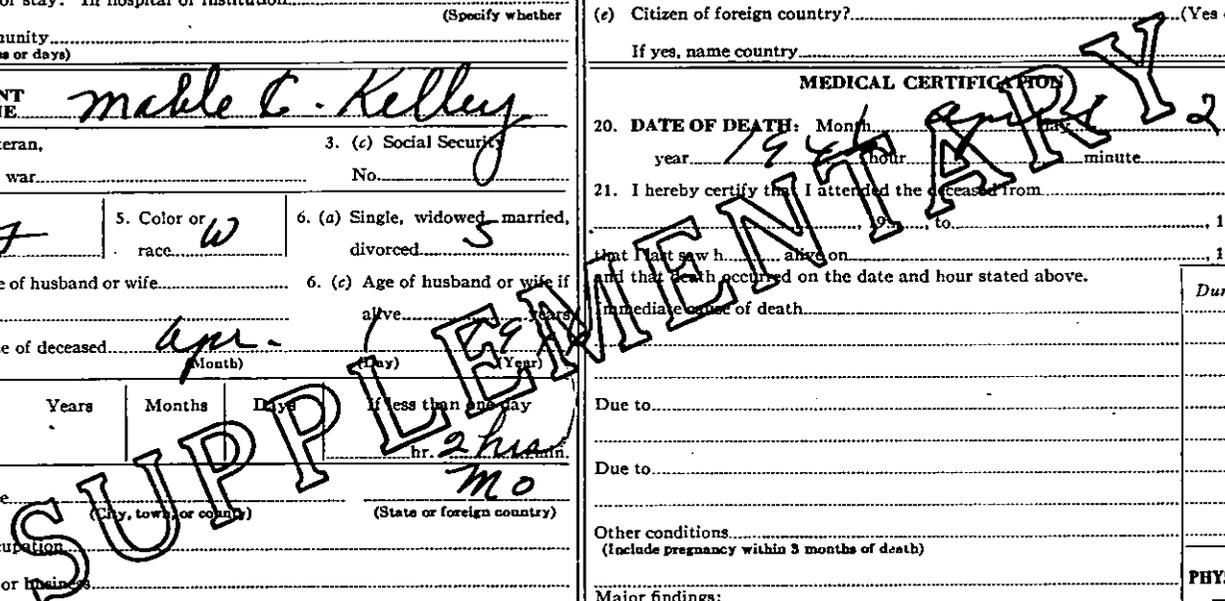
(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

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

Address _____ Date signed _____



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

MOTHER FATHER

16516