

S. No. 2  
M-2-43  
7-5-17-39  
P-1 X39597

DEPARTMENT OF COMMERCE  
BUREAU OF THE REGISTERS  
**FILED DEC 24 1946**

STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. 40877  
Registrar's No. 5259

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Keokuk  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 431 Montgall 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 45 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Jackson  
(c) City or town Keokuk  
(If outside city or town limits, write "RURAL")  
(d) Street No. 431 Montgall  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CARMEN TERINO  
3. (b) If veteran, name war no  
3. (c) Social Security No. unknown

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 12 day 12  
year 46 hour 1 minute 15 p. M.

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife Michiling  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: July 15 1871  
(Month) (Day) (Year)

I hereby certify that I attended the deceased from Dec. 1 1946 to Dec. 12 46  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

8. AGE: Years 75 Months 4 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Italy (City, town, or county) (State or foreign country)  
10. Usual occupation Labourer

Duration \_\_\_\_\_  
Due to Chronic Myocarditis  
Due to General Peritonitis  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations no Of autopsy \_\_\_\_\_

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Joe Terino  
13. Birthplace Italy (City, town, or county) (State or foreign country)  
14. Maiden name Lizzie DeBans  
15. Birthplace Italy (City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. Carl Civello  
(b) Address 431 Montgall  
17. (a) Burial (b) Date thereof 12/15/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt St Marys Cem  
18. (a) Signature of funeral director Sebbeta's  
(b) Address City  
19. (a) 12-14-46 (b) Estherdine Holmes  
(Date received local registrar) (Registrar's signature)

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) (a) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or officer)  
Address 68-11 St Date signed 12/13/46

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

15  
8  
10

**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 Ray E. Snow

Licensed Embalmer No. 2560

P. O. Address 1507 7th

**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.**