

S. No. 2  
OM-2-43  
v. 5-17-39  
X35697

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 9 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. 170

Primary Registration District No. 5635

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

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Conway  
(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) 1

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community entire life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede <sup>53</sup>

(c) City or town Conway <sup>0</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. no street address (If rural, give location)

(e) Citizen of foreign country? no (Yes or No) <sup>0</sup>  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jacob Emerson Kelly

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6  
year 1946 hour 6 minute 20 A.M.

21. I hereby certify that I attended the deceased from 12-1-46 1946 to 12-6-46 1946  
that I last saw h. alive on 12-1-46 1946  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race w 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mamie Burd 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased May 8 1879  
(Month) (Day) (Year)

Immediate cause of death myocarditis

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.

8. AGE: Years Months Days If less than one day

67 6 28 hr. \_\_\_\_\_ min.

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

10. Usual occupation Miller

11. Industry or business \_\_\_\_\_

12. Name Jacob Kelly

13. Birthplace Jackson Co Ohio (City, town, or county) (State or foreign country)

14. Maiden name Clasudarn Scurlock

15. Birthplace Jackson Co Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Mamie Kelly

(b) Address Conway Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-46 (Month) (Day) (Year)

(c) Place: burial or cremation Conway Cemetery

18. (a) Signature of funeral director W. E. Helman

(b) Address Lebanon Mo.

19. (a) 12-29-46 (Date received local registrar) (b) Geo. Famburger (Registrar's signature)

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 0

23. Signature J. W. Lindsey (M. D. or other) MD  
Address Conway Mo Date signed 12-16-46

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(Licensed Embalmer's Statement on Reverse Side)

Received ..... 1/3/46  
Laclede County Health Unit  
File No. .... 12-46-185  
Date Filed ..... 1/3/46

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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 Dorsey M. Howe  
Licensed Embalmer No. 4222  
P. O. Address Lebanon 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.**