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5-17-39
X47070

FILED FEB 4 1947
33

Registration District No. 33 Primary Registration District No. 3010

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

1. PLACE OF DEATH:
 (a) County Cape Girardeau
 (b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Francis Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days
(Specify whether
 In this community All of life
years, months or days)

3. (a) PRINT FULL NAME Jackie Gene Keen
 (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased January 21, 1947
(Month) (Day) (Year)

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

9. Birthplace Cape Girardeau, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

MOTHER FATHER

12. Name Charles Milford Keen
 13. Birthplace Benton, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Esther H. Turner
 15. Birthplace Fornfelt, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Milford Keen
 (b) Address RFD., Benton, Missouri

17. (a) Burial (b) Date thereof 1-29-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pollard Cemetery near Benton, Missouri

18. (a) Signature of funeral director Private
 (b) Address None

19. (a) 2-1-1947 (b) E. G. Summers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Scott
Benton, Rural
(If outside city or town limits, write "RURAL")
 (c) City or town
 (d) Street No. 5 Mi. Sou East of Benton
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 28th
 year 1947 hour 6:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from Jan 27, 1947 to Jan 28, 1947
 that I last saw him alive on Jan 28, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Intra Cerebral Hemorrhage
 Duration _____
 Due to Blow in Temp 8 days

Due to _____
 Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
 Of operations ✓ 160A
 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 0

23. Signature W. H. Keen (M. D. or other) MD
 Address Cape Girardeau Date signed 1-29-47

44

Health Officer No. 4
File Number 247-182
Date Filed 2-3-47

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.

Not Embalmed

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.