

No. 2  
12-45  
17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 28 1947**

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

**4558**

State File No. \_\_\_\_\_

Registration District No. 122

Primary Registration District No. 2000

Registrar's No. 112

**1. PLACE OF DEATH:**  
 (a) County Greene  
 (b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Springfield Baptist Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 Days  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo. (b) County Greene  
 (c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
 (d) Street No. R # 5  
(If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Presley Lee Keesling  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. None

4. Sex Female 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 February 2, 1947  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 4  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Infant  
 11. Industry or business At Home

**MOTHER** { 12. Name Charles Keesling  
 13. Birthplace Springfield Mo.  
 14. Maiden name Kathern Brooks  
 15. Birthplace Cave Springs Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Keesling  
 (b) Address R 5, Springfield Mo.  
 17. (a) Burial (b) Date thereof 2-7-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director W. H. Lingner & Co.  
 (b) Address Springfield Mo.  
 19. (a) 2-7-47 (b) W. H. Standley M.D.  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month February day 6 th  
 year 1947 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from 2-3  
 1947 to 2-6-1947  
 that I last saw her alive on 2-5-1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
Mal development  
Large tumor into nasal  
Due to Lack of Pt 2 ear  
& no eye ball in socket. 3 days  
 Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_ V  
 (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) (c) Means of injury  
 23. Signature C. E. Zeller (M. D. or other) \_\_\_\_\_  
 Address Springfield Mo. Date signed 2-7-47

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

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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.....

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.**