

FILED JUN 6 1947

Registration District No. 69

Primary Registration District No. 4122

Registrar's No. 19

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

1. PLACE OF DEATH: Christian

(a) County Christian

(b) City or town Nixa
(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 years, months or days)

In this community most of life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Christian

(c) City or town Nixa
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Besse Agnes Keltner

(b) If veteran, name war no

(c) Social Security No. none

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Walter Keltner

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

7. Birth date of deceased Jan. Dec. 24, 1873
(Month) (Day) (Year)

8. AGE: Years 74 Months 3 Days 3

If less than one day hr. _____ min. 0

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

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Homer Gilmore

13. Birthplace unknown
(City, town, or county) (State or foreign country)

14. Maiden name Lucy Lancaster

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Leonard Jones

(b) Address Nixa, Mo.

17. (a) burial (b) Date thereof Apr. 29, 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chastain cem.

18. (a) Signature of funeral director T.W. Maples

(b) Address Clever, Mo.

19. (a) May 19, 1947 (b) Alline Dreyer
(Data referred local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27
year 1947 hour _____ minute 45 P.M.

21. I hereby certify that I attended the deceased from Fall 1945 19. _____ to 4/4/47 19. 47
that I last saw her alive on 4/4/47 19. 47
and that death occurred on the date and hour stated above.

Immediate cause of death Remittent pulmonary malignancy

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations 50

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) (c) Means of injury _____

23. Signature W. Robert [unclear] (M. D. or other) MD

Address Springfield Date signed 5/24/47

RECEIVED

District Health Officer No. 6

District File No. 647-640

Date Filed JUN 5 1947

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 J. W. Maples

Licensed Embalmer No. 2985

P. O. Address Clever, 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.

EMBALMER

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 19

Registration District No. 69

Primary Registration District No. 7122

1. PLACE OF DEATH:
(a) County Christian
(b) City or town Nixa
(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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Bessie A. Keltner
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 _____

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

7. Birth date of deceased: Jan 24 (Month) (Day) (Year)

8. AGE: Years 74 Months _____ Days _____ (If less than one day) _____ hr. _____ min.

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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 June Year 1947 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 _____

Due to _____

Due to _____

Other conditions (include preposy within 3 months of death) _____

Major findings: Cancer of pelvis
Of operations _____

Of autopsy _____

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 _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

16858