

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 7 4 1947

Registration District No.

Primary Registration District No. 5-6-5-8

Registrar's No.

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Rural Vineyard
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Home Rt 2 Sarcope, Mo. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 40 years (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence

(c) City or town Rt 2 Sarcope, Mo
(If outside city or town limits, write "RURAL")

(d) Street No. Rt. 2
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Minnie Elizabeth Keith

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced T

6. (b) Name of husband or wife W.D. Keith 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Fe 5 1877
(Month) (Day) (Year)

8. AGE: Years 70 Months 3 Days 24 If less than one day hr. _____ min. _____

9. Birthplace Woyleton Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Henry Kreitemer 9
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Maria Breukman
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant W.D. Keith 1
(b) Address Rt 2 Sarcope, Mo

17. (a) Burial (b) Date thereof Jun 1-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East View Cemetery

18. (a) Signature of funeral director It S. Jones
(b) Address Lawrence Mo

19. (a) 7-20-47 (b) W.S. Beebe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29th
year 1947 hour 7 minute P. M.

21. I hereby certify that I attended the deceased from 2-20 1947 to 6-29 1947

that I last saw her alive on 6-23 1947

and that death occurred on the date and hour stated above.

Immediate cause of death Dilatative gangrene of back
Due to Fresh hip

Duration
4-14-47

Due to _____

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

Major findings: Of operations _____

Of autopsy 186 10

ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 55

(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 W.D. Keith (M. D. or other) 0

Address Sarcope Mo Date signed 5-31-47

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

RECEIVED

District Health Officer No. 6;

District File Number 847-814

Date Filed AUG 12 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.....

By *me*....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Max L. Fossett*.....

Licensed Embalmer No. *4252*.....

P. O. Address..... *Milwaukee, Wisc.*.....

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.

Registration District No. 176

Primary Registration District No. 5658

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Rural
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Miriam E. Veeth

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 M

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

7. Birth date of deceased 3 ex 5
(Month) (Day) (Year)

8. AGE: Years 70 Months 3 Days 24
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 _____ 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 _____

Duration

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.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) fell at home

(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 _____

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

SUPPLEMENTARY

S-24712