S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 15 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24800

Registration District No. 206 Primary Registration District No. 5744 Registrar's No. 21

1. PLACE OF DEATH:

(a) County: Madison

(b) City or town: Rural 8 mi. east of Fredericktown
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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: 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Madison

(c) City or town: Rural - Fredericktown R.F.D. #2
(If outside city or town limits, write "RURAL")

(d) Street No.: 8 mi. east of Fredericktown
(If rural, give location)

(e) Citizen of foreign country? - No - (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Rachel Catherine Keel

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: James Keel (deceased)

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

7. Birth date of deceased: March (Month) 23 (Day) 1870 (Year)

8. AGE: Years 77 Months 4 Days 10 If less than one day ..... hr. ..... min.

9. Birthplace: Bollinger Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business .....

FATHER
12. Name: Fred Shrum
13. Birthplace: Bollinger Co. (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name: Rachel Moran
15. Birthplace: unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Opel Elders
(b) Address: Fredericktown, mo.

17. (a) Burial (Burial, cremation or removal) (b) Date thereof: 8-6-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Crossroads Cemetery

18. (a) Signature of funeral director: Webb-Adamson
(b) Address: Fredericktown, mo.

19. (a) 8-8-1947 (Date received local registrar) (b) Florence Nickel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: August day: 2 year: 1947 hour: 6 minute: 00 P.M.

21. I hereby certify that I attended the deceased from June 15 1947 to Aug 2 1947 that I last saw her alive on July 29 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Arteriosclerosis (marked cerebral)	years
Due to: age	
Due to:	
Other conditions: Anaemia (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 0
Of autopsy: 0

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? (Specify type of place)
While at work? ..... (e) Means of injury: 0

23. Signature: S. C. Slaughter (M. D. or other)
Address: Fredericktown Mo. Date signed: 8-11-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

Number 847-105

Date Filed 8-14-47

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.

Signed L. Poljean Adamson

Licensed Embalmer No. 4351

P. O. Address Fredericktown, 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.