

No. 2
5-43
-17-39
X 36771

FILED AUG 7 1947

State File No. _____

Registration District No. ~~227~~

Primary Registration District No. 4340

Registrar's No. 43

1. PLACE OF DEATH:

(a) County Monroe, Louisiana
(b) City or town Florida, Mo
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Monroe, La
(c) City or town Florida
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

IRA-MOSS-KIETH

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex MO 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 7/11-1895
(Month) (Day) (Year)

8. AGE: Years 49 no 11 hr. min.

9. Birthplace: Victor, Monroe, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business none

12. Name Jayus W. Keith

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

14. Maiden name Anna E. Fletcher

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

16. (a) Informant Paul R. Fletcher

(b) Address 814 N. Olive, Mexico, Mo

17. (a) burial (b) Date thereof 7-28-47
(Manner, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Florida Cemetery

18. (a) Signature of funeral director Paul R. Fletcher

(b) Address Monroe, Mo

19. (a) 7/26-47 (b) Albert Baker, M.D.
(Date of medical registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
year 1947 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 1947 to July 26 1947
that I last saw him alive on July 20 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Harschpungis
childhood
H.A. Epilepsy from
Due to injury was a
quarrel

Duration

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) _____

(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 _____

23. Signature J. E. Brown (M. D. or other)

Address Ray, Mo Date signed 7-28-47

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 2-47-1022

Date Filed AUG - 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 *Fred W. Thompson*

Licensed Embalmer No. 1420

P. O. Address. *Madison, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug
431
Registrar's No. 431

Registration District No. _____ Primary Registration District No. 4340

1. PLACE OF DEATH:
(a) County Monroe
(b) City or town _____
(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 Ira Moss Keith
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 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 _____

7. Birth date of deceased July 1
(Month) (Day) (Year)

8. AGE: Years 49 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) Albert Baker M.D. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Monroe
(c) City or town Rural - Florida, mo (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 _____

Due to _____

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) _____
(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 _____

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

SUPPLEMENTARY 6

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

MOTHER FATHER

S-24875