

7. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36871

FILED SEP 18 1947

Registration District No. 360

Primary Registration District No. 3058

Registrar's No. 147

1. PLACE OF DEATH:

(a) County St Charles  
(b) City or town St Charles  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St Joseph O  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME MAHLINDA-KEYTH

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

4. Sex F 5. Color of race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife Mr Keyth 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 1 - 1874  
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 5 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation sewer

11. Industry or business \_\_\_\_\_

12. Name Mr MO 9

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

14. Maiden name Mr Quinn

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

16. (a) Informant Hospital Record

(b) Address St Charles MO

17. (a) Burial (b) Date thereof 8-7-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mountain City MO

18. (a) Signature of funeral director C. W. Slopman

(b) Address Mountain City MO

19. (a) 8/31/47 (b) Francis Hamilton  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Madison  
(c) City or town Fluss  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1 mile west Danville MO  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 6  
year 1947 hour 10 minute 10 M.

21. I hereby certify that I attended the deceased from 8/1 to 8/6 1947  
that I last saw him alive on 8/6/47 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Broken Bronchopneumonia Duration 3 days  
acute Chronic Cardiac Decomp. ?  
Due to arteriosclerotic heart disease ?  
Essential hypertension ?  
Due to \_\_\_\_\_  
Other conditions Repeated cerebral apoplexy ?  
(include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations Zygoma  
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 R. O. Hayden (M. D. or other) MO  
Address St Charles MO Date signed 8/7/47

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

2  
9  
3

Date Filed SEP 17 1947

District File Number

District Health Officer No. 9,

RECEIVED

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 on the  
6 day Aug 1947, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed C. W. Hopkins  
Licensed Embalmer No. 1487  
P. O. Address Unity Ave City 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.