

No. 2
8-43
17-39
1-37823

FILED DEC 4 1947

Registration District No. 287

Primary Registration District No. 5755

State File No.

Registrar's No. 49

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

1. PLACE OF DEATH:
 (a) County **Maries**
 (b) City or town **Freeburg, Mo. (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 **Lula Augusta Keeney**
 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 **married**
 6. (b) Name of husband or wife **J. S. Keeney** 6. (c) Age of husband or wife if alive **62** years
 7. Birth date of deceased **Aug. 7 1890**
 (Month) (Day) (Year)

8. AGE: Years **57** Months **3** Days **10** If less than one day
 hr. _____ min. _____

9. Birthplace **Maries County, Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Robert Franklin**

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

14. Maiden name **Martha Branson**

15. Birthplace **Maries County, Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **J. S. Keeney**

(b) Address **Freeburg, Mo.**

17. (a) Burial (b) Date thereof **11-20-1947**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place; burial or cremation **Liberty Cemetery**

(d) Signature of funeral director **H. C. Birmingham**

(e) Address **Vienna, Mo.**

(f) **11-25-47** (g) **Pauline Howard** (Registrar's signature) (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Maries** 63
 (c) City or town **Freeburg, Mo. (Rural)** 0
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? **No.** (Yes or No) 0
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **17**
 year **1947** hour **3** minute **10** A.M.

21. I hereby certify that I attended the deceased from
Aug. 19, 19 **46** to **Nov. 17,** 19 **47**
 that I last saw h **er** alive on **Nov. 17,** 19 **47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of the Liver** Duration _____

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 **2**

23. Signature **S. C. Howard** (M. D. or other) **D.** 0

Address **Vienna, Mo.** Date signed **11/24/47**

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 12-3-47

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed

Licensed Embalmer No. 3664

P. O. Address.....

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. See

Registration District No. 207

Primary Registration District No. 5755-

Registrar's No. 40

1. PLACE OF DEATH:

(a) County marion

(b) City or town Prud

(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 _____ (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 _____

3. (a) PRINT FULL NAME Lula A. Keeney

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 in

6. (b) Name of husband or wife _____

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

7. Birth date of deceased aug 7 1895

(Month) (Day) (Year)

8. AGE: Years 57 Months 3 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace mo

(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) 11-25-47 (b) Pauline Lawick

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 Day 22 Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I had seen _____ 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) (c) Means of injury _____

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

38888