

No. 2
-1/47
5-17-39

30531

State File No.

FILED SEP 20 1948 255

5875

Registrar's No.

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:

(a) County: Oregon

(b) City or town: Indiana, Ore.
(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: 9 mos
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town: Moreauville
(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: Laura Orleans Kelton

3. (b) If veteran, name war: ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4
year 1948 hour 10 minute 15 P. M.

4. Sex: F 5. Color or race: W 6. (a) Single, widowed, married, divorced: W 2

7. Name of husband or wife: W.C. Kelton 6. (c) Age of husband or wife if alive: 10-4-1876 years
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 10, 1948, to July 4, 1948;
that I last saw her alive on June 22, 1948;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
76 9 0 0 hr. min.

Immediate cause of death: Myo-carditis, chamber with acute edematous
Gastric Carcinoma

9. Birthplace: Oregon Co. Mo.
(City, town, or county) (State or foreign country)

Due to

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

10. Usual occupation: Homemaker

11. Industry or business:

Major findings: H&B

Of operations:

Of autopsy:

PHYSICIAN
Underline the cause of which death should be charged statistically.

12. Name: Mrs. A. Bates

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

14. Maiden name: Elizabeth Bates

15. Birthplace: Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant: Laura Kelton
(b) Address: Thomasville, Mo.

17. (a) R.S. (b) Date thereof: 7-5-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Richmond, Mo.

18. (a) Signature of funeral director: Bates
(b) Address: West Plains, Mo.

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? (g) Means of injury: 1

Signature: Ad. Thompson (M. D. or other) M.D.
Address: West Plains, Mo. Date signed: 7/13/48

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

MOTHER FATHER

RECEIVED 9-13-48
District Health Officer No. 5,
District File Number 24857
Date Filed 9-13-48

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 *D. S. Roberts*

Licensed Embalmer No. 3433

P. O. Address West Haven, Conn.

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. 255

Primary Registration District No. 5875

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Thomasville
(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 _____ (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 Faitha O. Ketrin

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 wid

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct 4
(Month) (Day) (Year)

8. AGE: Years 71 Months _____ Days _____ (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) 10-2-48 (b) mo w c Johnson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATE

20. DATE OF DEATH: Month _____ Year 1948 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 _____

21. Signature _____ (M. D. or other)
Address _____ Date signed _____

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

SUPPLEMENTARY

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

~~10-7-48~~
District Hospital
RECEIVED 10-7-48

1948

S-30531