

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31844

State File No. ....

FILED SEP 20 1948

Registration District No. 374

Primary Registration District No. 4547

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Worth  
(b) City or town Grant City Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Entire Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles Townsend Keyes

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Cora E Lyle Keyes 6. (c) Age of husband or wife if alive Not alive  
7. Birth date of deceased January 18 1868 (Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days 13 If less than one day hr. min.

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

10. Usual occupation Retired mail carrier

11. Industry or business mail carrier

12. Name Alpheus Keyes

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

14. Maiden name Sarah Ann Stevens

15. Birthplace Unknown Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Majorie Sparks

(b) Address Grant City Mo

17. (a) Burial (b) Date thereof Sept. 2-1948 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant City Cemetery

18. (a) Signature of funeral director John Anderson

(b) Address Grant City Mo

19. (a) Sept. 10 1948 (b) John C. Dawson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth  
(c) City or town Grant City Mo (If outside city or town limits, write "RURAL")  
(d) Street No. None (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 31 year 1948 hour 5 minute 40 P. M.

21. I hereby certify that I attended the deceased from July 10 to Aug 31, 1948  
that I last saw him alive on Aug 31, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction  
of heart Duration

Due to

Due to

Other conditions: Fractured left foot (Include pregnancy within 3 months of death) 3rd

Major findings: Fractured left foot 10/8

Of operations ✓

Of autopsy NO 921

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?

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

23. Signature John C. Dawson (M.D. or other)

Address Grant City Mo Date Sept. 1-48

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

**DISTRICT HEALTH OFFICE**  
**Cameron, Mo.**

**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.....

*John Andrew*....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*John Andrew*

Licensed Embalmer No. *4211*

P. O. Address *Grant 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.**