

FILED JAN 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 719

BIRTH NO.		REG. DIST. NO. 86		PRIMARY REG. DIST. NO. 4149		Registrar's No. 1-1949			
1. PLACE OF DEATH a. COUNTY Crawford				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Crawford					
b. CITY OR TOWN Cuba		c. LENGTH OF STAY (In this place) wife		c. CITY OR TOWN Cuba					
d. FULL NAME OF HOSPITAL OR INSTITUTION At Home of Levi West				d. STREET ADDRESS					
3. NAME OF DECEASED (Type or Print) a. (First) William			b. (Middle) Benton		c. (Last) KEEFER		4. DATE OF DEATH (Month) (Day) (Year) 1-9-1949		
5. SEX M.O.	6. COLOR OR RACE W	7. MARRIED-NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 2-5-1868		9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 11	IF UNDER 1 HRS. Days 4		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired Farmer		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Daniel KEEFER		13b. MOTHER'S MAIDEN NAME Amanda Stump		14. NAME OF HUSBAND OR WIFE Estella "Bell" KEEFER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture left hip				INTERVAL BETWEEN ONSET AND DEATH 3 wks 2 wks	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		ADDITIONAL INFORMATION			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) Cuba, Missouri (STATE)		21f. HOW DID INJURY OCCUR? REQUESTED 28			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22. I hereby certify that I attended the deceased from Dec 20, 1947, to Jan 9, 1949, that I last saw the deceased alive on Jan 7, 1949, and that death occurred at 1:30 p.m., from the causes and on the date stated above.									
23a. SIGNATURE J.A. Elders, M.D.				23b. ADDRESS Cuba, Mo.		23c. DATE SIGNED 1-10-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-11-49	24c. NAME OF CEMETERY OR CREMATORY Oakhill Cemetery		24d. LOCATION (City, town, or county) (State) Oakhill, Mo.				
DATE REC'D BY LOCAL REG. 1-17-49		REGISTRAR'S SIGNATURE Paul A. Shaulkin		FUNERAL DIRECTOR'S SIGNATURE Paul A. Shaulkin		ADDRESS Cuba, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

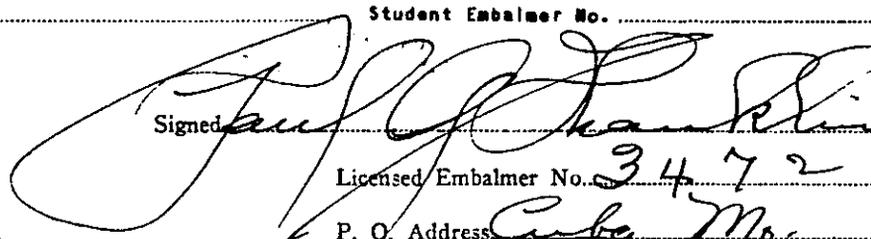
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

~~Date Filed~~
67-61-1
District File Number 14944
District Health Officer No. 5
RECEIVED 1-7-49

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.
Student
Student Embalmer

Student Embalmer No.
Signed 
Licensed Embalmer No. 3472
P. O. Address Cuba, 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.