

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4453**

BIRTH NO. 49-001119 REG. DIST. NO. 109 PRIMARY REG. DIST. NO. 5424 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>		
b. CITY OR TOWN <u>Rural Union Twp.</u>		c. LENGTH OF STAY (In this place) <u>Life</u>	c. CITY OR TOWN <u>Rural - Union Township</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>			d. STREET ADDRESS (If rural, give location) <u>R.R. 2</u>		

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>Betty</u>	b. (Middle) <u>Jane</u>	c. (Last) <u>Key</u>	<u>Jan. 24 1949</u>		

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>Jan. 24, 1949</u>	9. AGE (In years last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>4</u>	IF UNDER 10 HRS. Hours <u>4</u> Min.
----------------------	-------------------------------	--	---------------------------------------	--	---------------------------------	--------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	-----------------------------------	---	--

13a. FATHER'S NAME <u>Junior Key</u>	13b. MOTHER'S MAIDEN NAME <u>Lucille Bailey</u>	14. NAME OF HUSBAND OR WIFE
--------------------------------------	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Junior Key Campbell</u>	ADDRESS <u>Mo. R. 2</u>
---	-------------------------	--	-------------------------

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematured 5 months</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>776X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	--	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from Jan 24, 1949, to Jan 25, 1949, that I last saw the deceased alive on Jan 24, 1949, and that death occurred at 2:30pm., from the causes and on the date stated above.

23a. SIGNATURE <u>William L. Franklin</u>	(Degree or title) _____	23b. ADDRESS <u>Campbell Mo.</u>	23c. DATE SIGNED <u>2/12/49</u>
---	-------------------------	----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan. 25-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>North Caanon</u>	24d. LOCATION (City, town, or county) (State) <u>Campbell, Mo. R. 2</u>
---	-------------------------------	--	---

DATE REC'D BY LOCAL REG. <u>Feb. 21, 1949</u>	REGISTRAR'S SIGNATURE <u>Mrs. Beulah Campbell</u>	92	25. FUNERAL DIRECTOR'S SIGNATURE <u>Friends and neighbors</u>	ADDRESS
---	---	----	---	---------

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

RECEIVED
District Health Office
District File Number 249
Date Filed 3-28

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 _____

_____ Student Embalmer No. _____
working under my personal supervision.

Not Embalmed

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. _____

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.