

FILED JUN 11 1949

STANDARD CERTIFICATE OF DEATH

State File No. 15405

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 5379 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY De Kalb		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo, b. COUNTY DeKalb	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clarksdale, Sherman		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clarkdale, Rural, Sherman	
c. LENGTH OF STAY (In this place) Life		d. STREET ADDRESS (If rural, give location) 3 Miles N.E.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Elizabeth W. Ketchem HOME			

3. NAME OF DECEASED (Type or Print) Elizabeth MAX May Ketchem			4. DATE OF DEATH (Month) (Day) (Year) May 23 1949		
a. (First)		b. (Middle)	c. (Last)		

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 25, 1892		9. AGE (In years last birthday) 57	MONTHS 2	DAYS 28	IF UNDER 1 YEAR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Mo, ()		12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Wiley Wallace	13b. MOTHER'S MAIDEN NAME Mary Wallace	14. NAME OF HUSBAND OR WIFE Homer Ketchem	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Homer Ketchem Clarkdale Mo	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH 2 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension			
	DUE TO (c) _____			
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4-20-1

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from May 20, 1949, to May 23, 1949, that I last saw the deceased alive on May 23, 1949, and that death occurred at 4 P. m., from the causes and on the date stated above.

23a. SIGNATURE E. M. Reynolds, M.D. (Degree or title)	23b. ADDRESS Union Star Mo	23c. DATE SIGNED 5-24-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE 5-26-49	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St Joseph
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DATE REC'D BY LOCAL REG. 5-30-49	REGISTRAR'S SIGNATURE _____	FUNERAL DIRECTOR'S SIGNATURE _____	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 500
10-48
32
0

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.

Student
Student Embalmer

Signed _____

John Brown

Licensed Embalmer No. _____

3933

P. O. Address _____

Wayville, 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.