

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18377

FILED JUN 6 1949

BIRTH NO. 33206-39 REG. DIST. NO. 354 PRIMARY REG. DIST. NO. 6206 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Dessa</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Jackson</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Jackson</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED a. (First) <u>Leonard</u> b. (Middle) <u>Waym</u> c. (Last) <u>Kell</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 22 49</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>Apr 21 49</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days
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)	12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME <u>Leo Kell</u>	13b. MOTHER'S MAIDEN NAME <u>Nanda Callison</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Nanda Kell Raymondville</u> ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature birth 6 1/2 mo</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Breach Presentation</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		7615	

19a. DATE OF OPERATION <u>None</u>	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) <u>no</u>	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) (Min.)	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 Apr 21, 1949, to _____, 19____, that I last saw the deceased alive on Apr 21, 1949, and that death occurred at 39 m., from the causes and on the date stated above.

23a. SIGNATURE <u>Leslie Randall</u>	23b. ADDRESS <u>Licking Mo</u>	23c. DATE SIGNED <u>4-22-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>April 23</u>	24c. NAME OF CEMETERY OR CREMATORY <u>William Cemetery Texas Co</u>	24d. LOCATION (City, town, or county) (State) <u>Mo</u>
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DATE REC'D BY LOCAL REG. <u>April 23-49</u>	REGISTRAR'S SIGNATURE <u>Myrtle Craig</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Calvin Bailey</u> ADDRESS <u>No Funeral Director Licking Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED 5/16/49
District Health Officer No. 5,
District File Number 649380
Date Filed 6/2/49

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

Signed.....
Student Embalmer

Signed.....

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.