

FILED OCT 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34225

BIRTH NO. _____		REG. DIST. NO. <u>239</u>		PRIMARY REG. DIST. NO. <u>5825</u>		Registrar's No. <u>28</u>			
1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u>				b. COUNTY <u>New Madrid</u>	
b. CITY OR TOWN <u>Rural</u>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>Rural</u>		07220			
d. FULL NAME OF HOSPITAL OR INSTITUTION -----				d. STREET ADDRESS (If rural, give location) <u>R.F.D. #1, Lilbourn, Mo.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sarah</u>		b. (Middle) <u>Elizabeth</u>		c. (Last) <u>Keaster</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 8, 1950</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 8, 1878</u>		9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>1</u>	IF UNDER 1 WEEK Days <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired House-keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Stoddard County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13a. FATHER'S NAME <u>John Summers</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Canady</u>		14. NAME OF HUSBAND OR WIFE <u>W. G. Keaster</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>J. P. Keaster, R. 1, Lilbourn, Mo.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of Stomach</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <input checked="" type="checkbox"/> DUE TO (c) <input checked="" type="checkbox"/> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.		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 <u>March 5, 1950</u> , to <u>Sept 6, 1950</u> , that I last saw the deceased alive on <u>Sept 6, 1950</u> , and that death occurred at <u>11:00 a.m.</u> from the causes and on the date stated above.									
23a. SIGNATURE (Degree of title) <u>J. Carlstrom, M.D.</u>				23b. ADDRESS <u>Malden</u>		23c. DATE SIGNED <u>10/11/50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-9-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bernie</u>		24d. LOCATION (City, town, or county) (State) <u>Bernie, Missouri</u>				
DATE REC'D BY LOCAL REG. <u>10/21/50</u>		REGISTRAR'S SIGNATURE <u>D. Geo. H. Bush, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Strickland-Rainey</u>		ADDRESS <u>Dexter, Mo.</u>			

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

07
11

STATEMENT BY LICENSED EMBALMER

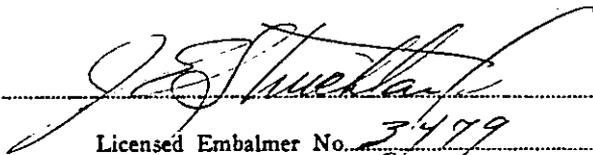
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student-Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. 3479

P. O. Address W. Va.

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.