

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6671**

FILED FEB 24 1953

BIRTH NO. _____		REG. DIST. NO. 170		PRIMARY REG. DIST. NO. 3032		Registrar's No. 23	
1. PLACE OF DEATH a. COUNTY Laclede				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Laclede			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Lebanon)		c. LENGTH OF STAY (In this place) 60 yrs.		c. CITY (If outside corporate limits, write RURAL and give township: 0533) OR TOWN Lebanon			
d. FULL NAME OF HOSPITAL OR INSTITUTION Wallace Hospital				d. STREET ADDRESS (If rural, give location) 805 St. Louis Street			
3. NAME OF DECEASED (Type or Print) a. (First) Fannie		b. (Middle)		c. (Last) Keen		4. DATE OF DEATH (Month) (Day) (Year) Feb. 11, 1953	
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Oct 12, 1868	
9. AGE (In years last birthday) 84		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Laclede Co. Missouri	
11. BIRTHPLACE (City and State or Foreign Country) Laclede Co. Missouri		12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Ben Smith		13b. MOTHER'S MAIDEN NAME Not known	
14. NAME OF HUSBAND OR WIFE Bud Keen		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, specify unknown) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Joe Keen, Lebanon, Mo.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral apoplexy ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 334X				INTERVAL BETWEEN ONSET AND DEATH 1-4-53	
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)		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 1-4-53 , to 3-11-53 , that I last saw the deceased alive on 2-7-53 , and that death occurred at 11:25 AM , from the causes and on the date stated above.							
23a. SIGNATURE R E Howell (Degree or title) MD				23b. ADDRESS Lebanon Mo		23c. DATE SIGNED 2-15-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/13/53		24c. NAME OF CEMETERY OR CREMATORY Lebanon Cem.		24d. LOCATION (City, town, or county) (State) Lebanon, Mo.	
DATE REC'D BY LOCAL REG. 2-16-1953		REGISTRAR'S SIGNATURE Hella L. Gray		25. FUNERAL DIRECTOR'S SIGNATURE Galbraith		ADDRESS Lebanon Mo.	

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

Received FEB 21 1953
Laclede County Health Unit
File No. 2-53-29
Date Filed FEB 21 1953

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 S. P. Palmer

Licensed Embalmer No. 2208

P. O. Address Libanon, 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.