

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 14 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 275 PRIMARY REG. DIST. NO. 3053 Registrar's No. 77

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived prior to institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Marion</u>	
b. CITY OR TOWN <u>Kalbs Mo</u>		c. CITY OR TOWN <u>Union Mo</u>	
c. LENGTH OF STAY (In this place) <u>6 Mo</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McFarland Nursing Home</u>		e. STREET ADDRESS (If rural, give location) <u>0630</u>	

3. NAME OF DECEASED a. (First) <u>VINCENT</u> b. (Middle) <u>D</u> c. (Last) <u>KEENEY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 9, 1953</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Oct 7, 1875</u>		9. AGE (In years last birthday) <u>77</u>		10. IF UNDER 1 YEAR Days <u>6</u> IF UNDER 1 HRS. Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>William Keene</u>		13b. MOTHER'S MAIDEN NAME <u>O. Stewart</u>		14. NAME OF HUSBAND OR WIFE <u>Clara Keene</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Clara Keene</u> ADDRESS <u>Union Mo</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arteriosclerotic heart disease</u>		DUPLICATE OF (a)		<u>2 yrs (?)</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUPLICATE TO (b)			
		DUPLICATE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS			
		Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</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 4-3 5:30 1953, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on 4-3, 1953, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>E. E. Feind M.D.</u> (Degree or title)		23b. ADDRESS <u>Rolla Mo.</u>		23c. DATE SIGNED <u>4-9-53</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		24b. DATE <u>4-11-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian</u>		24d. LOCATION (City, town, or county) (State) <u>Union Mo</u>	
DATE REC'D BY LOCAL REG. <u>Apr. 9, 1953</u>		REGISTRAR'S SIGNATURE <u>Nadine L. Steel</u>		25. EMERALD DIRECTOR'S SIGNATURE <u>McFarland</u>		ADDRESS <u>Union Mo</u>	

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

0812

Courtesy File Number  
Date Filed 4-13-53

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.....  
Signature of Student Embalmer

Signed *McB...*  
.....

Licensed Embalmer No. 3664

P. O. Address *Genia*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.