

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **18888**

No. 300
10-48

FILED JUN 3 1953

BIRTH NO. _____ REG. DIST. NO. **274** PRIMARY REG. DIST. NO. **3052** Registrar's No. **171**

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

1. PLACE OF DEATH a. COUNTY Pettis		2. USUAL RESIDENCE (Where deceased lived. If institution: rank/grade before admission) a. STATE Missouri b. COUNTY Pettis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia	c. LENGTH OF STAY (in this place) 1 day	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bothwell Hospital		d. STREET ADDRESS (If rural, give location) None	

3. NAME OF DECEASED (Type or Print) DAVID			4. DATE OF DEATH (Month) (Day) (Year) May 23, 1953	
a. (First)	b. (Middle)	c. (Last) KEELE		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH May 23, 1953	9. AGE (in years last birthday) / 13 MO / 30 D / 0 M.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Sedalia, Missouri
				12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Clarence Keele	13b. MOTHER'S MAIDEN NAME Anna Hollcroft	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clarence Keele, Sedalia, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Percipitate delivery DUE TO (c) Congenital atelectasis	INTERVAL BETWEEN ONSET AND DEATH 12 hrs 12 hrs
19a. DATE OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 76100
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 23 May 1953, to 23 May 1953 that I last saw the deceased alive on 23 May, 1953, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Type or Print) Carl Siegel M.D.	23b. ADDRESS 1216 West 18th St. Sedalia, Mo.	23c. DATE SIGNED 23 May 53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/25/1953	24c. NAME OF CEMETERY OR CREMATORY Crown Hill Cemetery	24d. LOCATION (City, town, or county) (State) Sedalia, Missouri

DATE REC'D BY LOCAL REG. 5-27-53	REGISTRAR'S SIGNATURE R. J. Campbell M.D.	FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. A. Swartz Sedalia, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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 Russell C. Maag

Licensed Embalmer No. 4807

P. O. Address Sedalia, 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.