

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

State File No. **12656**

FILED MAY 14 1954

No. 200  
10-48  
0610

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **200** PRIMARY REG. DIST. NO. **574L** Registrar's No. **226**

1. PLACE OF DEATH a. COUNTY <b>Macon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Macon</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural-Russell Twp.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural-Russell Twp.</b>	
c. LENGTH OF STAY (in this place) <b>29 yrs</b>		d. STREET ADDRESS (If rural, give location) <b>5 miles N. of New Cambria</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5 miles N. of New Cambria</b>		e. FULL NAME OF HOSPITAL OR INSTITUTION <b>5 miles N. of New Cambria</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Lula</b> b. (Middle) <b>Jane</b> c. (Last) <b>Kelley</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>March 23, 1954</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 14, 1890</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months <b>II</b> Days <b>8</b>	IF UNDER 24 HRS. Hour <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Macon county, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>

13a. FATHER'S NAME <b>Daniel Cohoon</b>	13b. MOTHER'S MAIDEN NAME <b>Adeline Davolt</b>	14. NAME OF HUSBAND OR WIFE <b>Charley Kelley</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>No.</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Charley Kelley, New Cambria, Mo.</b>	ADDRESS <b></b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>27 mos +</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Pancreas</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma head of Pancreas 157X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **2/2**, 19**54**, to **3/20**, 19**54**, that I last saw the deceased alive on **3/20**, 19**54**, and that death occurred at **2:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>James E. Campbell, M.D.</b>	23b. ADDRESS <b>Macon Mo</b>	23c. DATE SIGNED <b>April 26</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>3-24-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>New Cambria</b>	24d. LOCATION (City, town, or county) (State) <b>New Cambria, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>3/23/54</b>	REGISTRAR'S SIGNATURE <b>Paul M. Veely</b>	185	25. FUNERAL DIRECTOR'S SIGNATURE <b>H. H. Killeland</b>	ADDRESS <b>New Cambria Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 5.10.54  
MACON COUNTY HEALTH DEPARTMENT  
County File No. 5.54.76  
Date Filed 5.12.54

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 H. J. Gilliland  
Licensed Embalmer No. 4019  
P. O. Address New Cambria, 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.