FILED JUL 6 1954

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19817

BIRTH NO. _____ REG. DIST. NO. 254 PRIMARY REG. DIST. NO. 4385 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY: OREGON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KOSHKONONG,
c. LENGTH OF STAY (in this place): 3 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): X X

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: OREGON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KOSHKONONG, 0750
d. STREET ADDRESS (If rural, give location): R F D

3. NAME OF DECEASED (Type or Print): a. (First) ELLEN b. (Middle) J. c. (Last) KELTNER
4. DATE OF DEATH (Month) (Day) (Year): 5-14-54
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH:
9. AGE (In years last birthday): 84 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: X
11. BIRTHPLACE (State or foreign country): UNK
12. CITIZEN OF WHAT COUNTRY? U S A
13a. FATHER'S NAME: UNK
13b. MOTHER'S MAIDEN NAME: UNK
14. NAME OF HUSBAND OR WIFE: W. H. KELTNER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): X (If yes, give war or dates of service): X
16. SOCIAL SECURITY NO.: X
17. INFORMANT'S SIGNATURE OR NAME: ODELL SANDERS, KOSHKONONG, MO ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis —

DUE TO (c) Senility.

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: 331 X
20. AUTOPSY? YES ☐ NO ☐
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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-14, 19 54, *to* 5-14, 19 54, *that I last saw the deceased alive on* 5-14, 19 54, *and that death occurred at* 2:15 *m. from the causes and on the date stated above.*

23a. SIGNATURE: Odell Cooper (Degree or title): M.D.
23b. ADDRESS: Thayer Ore
23c. DATE SIGNED: 6-14-54

24a. BURIAL, CREMATION, REMOVAL (Specify): R
24b. DATE: 5-14-54
24c. NAME OF CEMETERY OR CREMATORY: Pauls Valley, Okla
24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: JUL 6 1954
REGISTRAR'S SIGNATURE: Blyde G. Bridges
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robertsons, West Plains, Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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 D S Roberts

Licensed Embalmer No. 3432

P. O. Address West Plains

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.