

FILED AUG 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29481**

BIRTH NO. _____		REG. DIST. NO. 322		PRIMARY REG. DIST. NO. 3071		Registrar's No. 155	
1. PLACE OF DEATH a. COUNTY Saline				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Saline			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater		c. LENGTH OF STAY (In this place) 66 YRS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater			
d. FULL NAME OF HOSPITAL OR INSTITUTION none				d. STREET ADDRESS (If rural, give location) 117 E. Parker			
3. NAME OF DECEASED (Type or Print) a. (First) Amos b. (Middle) Henry c. (Last) Keyton			4. DATE OF DEATH (Month) (Day) (Year) Aug. 9th-1954				
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single		8. DATE OF BIRTH Apr. 7th, 1888	
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months 4 Days 2		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during usual working hours, even if retired) laborer			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and State or Foreign Country) Saline Co. Mo. 0		12. CITIZEN OF WHAT COUNTRY? 0
13a. FATHER'S NAME Addison Keyton			13b. MOTHER'S MAIDEN NAME Susan E. Dilley		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. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rufus Keyton Slater, 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) Carcinoma of the Stomach ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) unknown DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. logorrhea					INTERVAL BETWEEN ONSET AND DEATH 3 months
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION: 151X					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) 2:21		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 Feb 1902, 19 , to August 9, 1954 , that I last saw the deceased alive on August 9, 1954 , and that death occurred at 6:2 m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J. Nelson			23b. ADDRESS 214 1/2 N. Main St.		23c. DATE SIGNED 8-10-54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/11/1954		24c. NAME OF CEMETERY OR CREMATORY Fish Creek		24d. LOCATION (City, town, or county) (State) R.F.D. Slater, Mo.	
DATE REC'D BY LOCAL REG. 8-12-54		REGISTRAR'S SIGNATURE Mrs. Earl C Metz		25. FUNERAL DIRECTOR'S SIGNATURE Hill Brothers		ADDRESS Slater Mo.	

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

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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 Sam M Neil

Licensed Embalmer No. 1292

P. O. Address Slater 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.