

No. 300
10.48

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4359

State File No.

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 5374 Registrar's No. 8

0320

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

1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>DeKalb</u>	
b. CITY (If outside corporate limits, write BUREAU OF HEALTH (By the health officer) OR TOWN <u>Osborn</u> <u>Colled</u>)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural # 4 North 1 East</u> <u>0320</u>	
c. LENGTH OF STAY (If in place) <u>life</u>		d. STREET ADDRESS (If rural, give location) <u>5 Mi., N.E. of town</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u> <u>5 Mi., N.E. of town</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Nora</u>	b. (Middle) <u>Alona</u>	c. (Last) <u>Kelley</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1 - 19 55</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 10 1875</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Ben Kelley</u>	13b. MOTHER'S MAIDEN NAME <u>Annie Robinson</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>XXXXXXXXXX</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Albert Bailey</u>	ADDRESS <u>Osborn Mo.</u>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>27 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u>		
	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	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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 12/24, 1954 to 1/19, 1955 that I last saw the deceased alive on 1/19, 1955, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. Harold Fowler</u>	23b. ADDRESS <u>Maysville Mo</u>	23c. DATE SIGNED <u>1/20/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1-21-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Osborn</u>	24d. LOCATION (City, town, or county) (State) <u>Osborn Mo</u>
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DATE REC'D BY LOCAL REG. <u>2-25-55</u>	REGISTRAR'S SIGNATURE <u>Robert Davidson</u> <u>82</u>	25. GENERAL DIRECTOR'S SIGNATURE <u>John S. Beam</u>	ADDRESS <u>Maysville Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

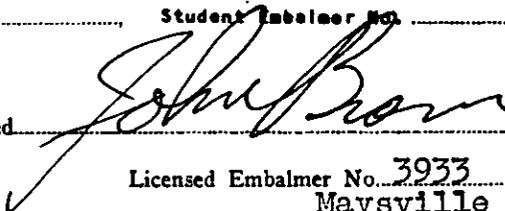
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

.....
working under my personal supervision.

Student Embalmer No. _____

Signed _____



Signed.....
Student Embalmer

Licensed Embalmer No. 3933
Maysville Mo
P. O. Address _____

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.