

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4440

State File No.

BIRTH NO. _____ REG. DIST. NO. 113 PRIMARY REG. DIST. NO. 485 Registrar's No. 512

360
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Clair		c. LENGTH OF STAY (in this place) 25 yrs		c. CITY OR TOWN St. Clair	
d. FULL NAME OF HOSPITAL OR INSTITUTION Table Street		STREET ADDRESS (If rural, give location) 0360		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) George	b. (Middle) Edward	c. (Last) Kee	(Month) Feb.	(Day) 21	(Year) 1955
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 20, 1879	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Public Works	11. BIRTHPLACE (City and State or Foreign Country) Moselle, Mo.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Joshua Kee	13b. MOTHER'S MAIDEN NAME Elizabeth Arnold	14. NAME OF HUSBAND OR WIFE Fannie Kee
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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) No	16. SOCIAL SECURITY NO. 498-03-2156	17. INFORMANT'S SIGNATURE OR NAME Fannie Kee	ADDRESS St. Clair, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Primary		DUE TO (b) Bronchopneumonia		48 hrs.
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Pyelocystitis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				2 yrs.
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 491X			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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)	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 June, 1954, to 2-21, 1955, that I last saw the deceased alive on 2-21, 1955, and that death occurred at 3P. m., from the causes and on the date stated above.

23a. SIGNATURE W. E. Mitchell (Degree or title)	23b. ADDRESS St. Clair - Mo	23c. DATE SIGNED 2-22-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 24, 1955	24c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery	24d. LOCATION (City, town, or county) (State) St. Clair, Mo.
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DATE REC'D BY LOCAL REG. 2-24-55	REGISTRAR'S SIGNATURE Philip Williams 511	25. FUNERAL DIRECTOR'S SIGNATURE Casey & Lerot	ADDRESS St. Clair, Mo
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MAR 5 1954

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.....
Signature of Student Embalmer

Signed *R. M. Leno*.....

Licensed Embalmer No. *360*

P. O. Address *St. Clair,*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.