

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

**58-039779**  
STATE FILE NUMBER

**FILED DEC 1 1958** Registration District No. 145 Primary Registration District No. 5566 Registrar's No. \_\_\_\_\_

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Iron</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Iron</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN. <u>Middlebrook</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Middlebrook</u> <u>0478</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <u>4 yrs</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MATTIE</u> <u>MARTHA</u> <u>KEITH</u>			4. DATE OF DEATH Month Day Year <u>Nov.</u> <u>22</u> <u>1958</u>		
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5. SEX <u>fem</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11 1875</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>Jackson Tenn.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Wesley Anderson</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Pryor</u>	14. NAME OF HUSBAND OR WIFE <u>John F. Keith</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT Address <u>Bill Keith, Ava Illinois</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) _____	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	DUE TO (c) <u>Arteriosclerotic heart disease.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>8-29-58</u> to <u>11-22-58</u> and last saw her alive on <u>11-13-58</u> Death occurred at <u>12.30 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Marvin C. Menne, M.D.</u>	22b. ADDRESS <u>109 N. Main, Ironton, Missouri</u>	22c. DATE SIGNED <u>11-24-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>11-25-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nelson Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Belleview Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>White Funeral Home, Ironton Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Nov 28 - 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Elizabeth Logan</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

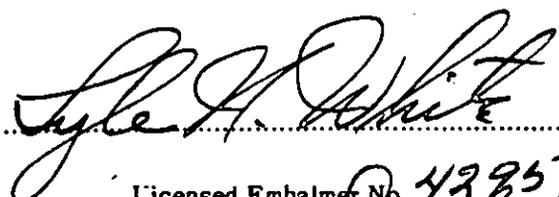
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 .....



Licensed Embalmer No. 4295

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