

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS SEP 28 1959

59-031400

STATE FILE NUMBER

Registration District No. 11 Primary Registration District No. 5042 Registrar's No. 73

DED

1. PLACE OF DEATH a. COUNTY <u>Barry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Barry</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Liberty Twp.</u>			Length of stay in 1b		c. CITY OR TOWN <u>Purdy</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) RESIDE ON FARM Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>JESS</u> Middle <u>JOHN</u> Last <u>KEELING</u>				4. DATE OF DEATH <u>AUGUST 29, 1959</u> Month <u>29</u> Day <u>1959</u> Year			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-2-1889</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (City and state or country) <u>Barry County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>James M. Keeling</u>			13b. MOTHER'S MAIDEN NAME <u>Ann Eden</u>			14. NAME OF HUSBAND OR WIFE <u>Leora Jones Keeling</u>	
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>500-40-9721</u>		17. INFORMANT Address <u>Mrs. Leora Keeling-Purdy, Missouri</u>			
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 Thrombosis</u> DUE TO (b) <u>Unknown</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)					
20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year a.m. <u>  </u> p.m. <u>  </u>		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	
21. I attended the deceased from <u>2/24/55</u> to <u>8/29/59</u> and last saw him alive on <u>6-16-59</u> Death occurred at <u>6:00 am 8/29/59</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Paul K. Starnes Sr</u> (Degree or title)				22b. ADDRESS <u>Purdy Mo</u>		22c. DATE SIGNED <u>8/24/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-1-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cemetery</u>		23d. LOCATION (City, town, or county) <u>Barry County, Missouri</u> (State)		
24. FUNERAL DIRECTOR <u>Culver's</u>		ADDRESS <u>Cassville, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>9-9-1959</u>	26. REGISTRAR'S SIGNATURE <u>Grace Williams</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Margaret C. Hemb

Licensed Embalmer No. 4380

P. O. Address Cassville

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.