

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005892

FILED VS FEB 23 1960

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 169C

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Boone				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield, Missouri		Length of stay in 1b 18 Hours		c. CITY OR TOWN Harrison		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) South Highway 65			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HAROLD BLAINE KEIGHIN				4. DATE OF DEATH Month Day Year February 9, 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/14/1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer			10b. KIND OF BUSINESS OR INDUSTRY Railway		11. BIRTHPLACE (City and state or country) Kempton, Illinois		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Kathryne Keighin		
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. Unknown		17. INFORMANT Address Mrs. P. C. Dahn Harrison, Arkansas			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) acute nephrosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 4 days 7 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic myelogenous Leukemia						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 checked="" type="checkbox"/> NO <input 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 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 Springfield, Missouri		COUNTY	STATE	
21. I attended the deceased from 2/8/59 to 2/9/59 and last saw her/him alive on 2/9/59 Death occurred at 2:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Thomas Cochran M.D.				22b. ADDRESS Springfield, Missouri			22c. DATE SIGNED 2/10/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2/10/60	23c. NAME OF CEMETERY OR CREMATORY Chicago, Illinois		23d. LOCATION (City, town, or county) Chicago, Illinois			
24. FUNERAL DIRECTOR Ayre*Goodwin Springfield, Mo.				25. DATE RECD. BY LOCAL REG. 2-15-60		26. REGISTRAR'S SIGNATURE Effie S. Melton		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 7 1960

MAY 24 1960

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed

Harry [Signature]

Licensed Embalmer No. 4594

P. O. Address Springfield,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.