

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS APR 25 1960

-60-014878

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 461

|   |  |   |  |  |   |   |   |
|---|--|---|--|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Greene</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Stone</u> |   |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Springfield</u>   |  | Length of stay in 1b<br><u>3 weeks</u>  |  | c. CITY OR TOWN <u>Galena</u>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><u>No street address</u>  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>MARGARET</u> Middle <u>M.</u> Last <u>KELLY</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>20</u> Year <u>1960</u>  |   |   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>June 12, 1880</u>   | 9. AGE (last birthday)<br><u>79</u>   | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HR<br>Hours _____ Min. _____    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>                                 |  | 11. BIRTHPLACE (City and state or country)<br><u>Tulon, Illinois</u>  |   | 12. CITIZEN OF WHAT COUNTRY<br><u>U S A</u> |
| 13a. FATHER'S NAME<br><u>R. H. McKeighan</u>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Amelia Wright</u>                                    |  | 14. NAME OF HUSBAND OR WIFE<br><u>John M. Kelly</u>   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |   | 16. SOCIAL SECURITY NO.<br><u>440-61-7939</u>  | 17. INFORMANT<br>Address<br><u>John M. Kelly, Galena, Missouri</u>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Juvenile due to drug reaction</u>  |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u>                                     |   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Uremia</u>  |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u>                                     |   |
| DUE TO (c) <u>Arterio nephrosclerosis</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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |
| 19. WAS AUTOPSY PERFORMED<br>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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____   |  |   |  |  |   |   |   |
| 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>3-28-60</u> to <u>4-20-60</u> and last saw <sup>her</sup> <sub>live</sub> arrive on <u>4-20-60</u><br>Death occurred at <u>8:15 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><u>Cliff R. Owen M.D.</u>   |  |   |  | 22b. ADDRESS<br><u>404 Professional Bldg.</u>  |   | 22c. DATE SIGNED<br><u>April 22 1960</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   | 23b. DATE<br><u>April 20, 1960</u>     | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Galena Cemetery</u>  |  | 23d. LOCATION (City, town, or county) <u>Galena, Missouri</u> (State)  |   |   |   |
| 24. FUNERAL DIRECTOR<br><u>Jewell E. Winkle</u> ADDRESS <u>B.W. Springfield, Mo.</u>  |  |   | 25. DATE RECD. BY LOCAL REG.<br><u>4-22-60</u>                                       |  | 26. REGISTRAR'S SIGNATURE<br><u>Effie E. Melton</u>   |   |   |

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Bernard F. Wright

Licensed Embalmer No. 429

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.