

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**61-016801**

STATE FILE NUMBER

AMENDED

Registration District No. 69 Primary Registration District No. 5273 Registrar's No. 6

**FILED** MAY 22 1961

1. PLACE OF DEATH a. COUNTY <b>Christian</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>(Christian)</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Porter Township</b>		Length of stay in 1b <b>60 yrs</b>	c. CITY OR TOWN <b>Brookline</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Route 1, Brookline</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Route 1</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALMOND FULTON KELTNER</b>			4. DATE OF DEATH Month Day Year <b>April 29 1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 15, 1874</b>
9. AGE (last birthday) <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Greene Co., Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Thomas Benton Keltner</b>	
13b. MOTHER'S MAIDEN NAME <b>Sarah McCroskey</b>		14. NAME OF HUSBAND OR WIFE <b>--</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Felix Keltner, Brookline, Mo.</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>(arterio-sclerosis - generalized)</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
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 a.m. p.m. 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>1-20-61</u> to <u>4-29-61</u> and last saw him alive on <u>4-22-61</u> Death occurred at <u>11:00 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Thomas Keltner, M.D.</b>		22b. ADDRESS <b>Springfield, Mo.</b>	22c. DATE SIGNED <b>5/4/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 2, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Manley</b>	23d. LOCATION (City, town, or county) (State) <b>near, Springfield, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Jewell E. Windle, Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>May 17, 1961</b>	26. REGISTRAR'S SIGNATURE <b>Olive Hutter</b>

DATE AMENDED  
INSTEAD OF  
ITEM NO. SHOULD READ  
BY AFFIDAVIT OF

DOCUMENT  
MEDICAL CERTIFICATION

**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 Bernard F. Wright

Licensed Embalmer No. 4293

P. O. Address Springfield

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.