

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-63-014581**  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 94

**FILED APR 11 1963**

DO NOT WRITE ON THIS STUD	AMENDED				
VS 300 Rev. 4/59	DATE AMENDED				
1007					
20670					
3					
4 3					
5 0					
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7 0					
8 2					
9762.0					
10					
11					
12 1-0					
13 2-0					
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF				
USE BLACK INK OR TYPEWRITER RIBBON	DOCUMENT				
BY AFFIDAVIT OF	MEDICAL CERTIFICATION				
ITEM NO.	SHOULD READ				

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Sikeston</u>		Length of stay in 1b <u>1 1/2 days</u>	c. CITY OR TOWN <u>Charleston</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 <u>Mo. Delta Community</u>		Inside Units Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. #1 Box 104</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Renita Keller</u>			4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>63</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-6-68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (last birthday) Months <u>2</u> Days <u>2</u>
11a. FATHER'S NAME <u>A. B. Keller</u>		11. BIRTHPLACE (City and state or country) <u>Wyatt Mo.</u>	
13b. MOTHER'S MAIDEN NAME <u>Cassie B. Rice</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. NAME OF HUSBAND OR WIFE <u>Ret. 1st Lt. 1st 104</u>	
16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT <u>A. B. Keller, Rt. 1, Box 104, Charleston Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO (b) <u>Medullary Damage</u> DUE TO (c) <u>Heartd Hypoxia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</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>7-15 A</u> Month, Day, Year <u>4-8-63</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Charleston Mo.</u>		COUNTY STATE
21. I attended the deceased from <u>4-6-63</u> to <u>4-8-63</u> and last saw her <u>live</u> on <u>4-8-63</u> Death occurred at <u>7:15 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph C. Hunter M.D.</u>		22b. ADDRESS <u>1012 N Main Sikeston Mo</u>	22c. DATE SIGNED <u>4-8-63</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>4-9-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sak Grove Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Charleston Mo.</u>
24. FUNERAL DIRECTOR <u>Doris Charleston Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>April 9 1963</u>	26. REGISTRAR'S SIGNATURE <u>Jeanette Williams</u>

(Licensed Embalmer's Statement on Reverse Side)

Permit issued April 8, 1963

**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 Willie R. Davis

Licensed Embalmer No. 5129

P. O. Address Charleston MD,

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.