

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001110

STATE FILE NUMBER

16

Registration District No. 137 Primary Registration District No. Registrar's No.

300
-57

1. PLACE OF DEATH
a. COUNTY Henry
b. CITY (If outside corporate limits, give TOWNSHIP only) Montrose Inside Limits Yes No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bear Creek Camp Length of stay in lb life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Henry
c. CITY OR TOWN Montrose 0420c Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) Bear Creek Camp Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last FRANK OLIVER KELLAND
4. DATE OF DEATH Month Day Year Jan. 14 1959
5. SEX Male 6. COLOR OR RACE white 7. MARRIED NEVER MARRIED WIDOWED DIVORCED
8. DATE OF BIRTH Aug 21 - 1895 9. AGE (Years last birthday) 63 IF UNDER 1 YEAR Months 4 Days 23 Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier 10b. KIND OF BUSINESS OR INDUSTRY none 11. BIRTHPLACE (City and state or country) Brooklyn N.Y. 12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John Kelland 13b. MOTHER'S MAIDEN NAME Ellen Hilland 14. NAME OF HUSBAND OR WIFE May L Kelland
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. 9 17. INFORMANT Frank Kelland Jr Address Montrose Mo St 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION INTERVAL BETWEEN ONSET AND DEATH INSTANT
DUE TO (b) ACUTE MYOCARDITIS 1 MO.
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 1955, to Jan 14, 1959 and last saw him alive on Jan. 11, 1958
Death occurred at 8 p on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Hugh B. Walker, MD 22b. ADDRESS Clinton, Mo 22c. DATE SIGNED Jan 14, 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 1-18-59 23c. NAME OF CEMETERY OR CREMATORY Montrose Ceme. 23d. LOCATION (City, town, or county) (State) Montrose Mo

24. FUNERAL DIRECTOR ADDRESS Dehabing Funeral Home Clinton Mo 25. DATE RECD. BY LOCAL REG. 1-12-59 26. REGISTRAR'S SIGNATURE Mildred Bigum

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

JAN 26 1959

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 F. L. Schubert

Licensed Embalmer No. 42513

P. O. Address Clinton

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.