

**FILED** OCT 12 1945

Registration District No. **316**

Primary Registration District No. **6074**

Registrar's No. **160**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**

(a) County St. Francois

(b) City or town Dealey, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or (days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Francois **9.4**

(c) City or town Dealey, Mo **0**  
(If outside city or town limits, write "RURAL") **0**

(d) Street No. \_\_\_\_\_ (If rural, give location) **0**

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Nelda Lucille Keel

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or white race Cauc

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
alive \_\_\_\_\_ years

7. Birth date of deceased: January 27 1939  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>6</u>	<u>7</u>	<u>20</u>	hr. _____ min. _____

9. Birthplace Farmington R. 2 Mo 2 **0**  
(City, town, or county) (State or foreign country)

10. Usual occupation chad

**MOTHER FATHER**

11. Industry or business \_\_\_\_\_

12. Name Mr. Jerry O. Leary Keel

13. Birthplace Farmington R. 2 Mo 2 **0**  
(City, town, or county) (State or foreign country)

14. Maiden name Lucille Carver

15. Birthplace Reynolds Co. Mo 1 **0**  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Mrs. Jerry O. Keel Fitch, Mo 2

(b) Address Dealey, Mo.

17. (a) Burial (b) Date thereof 9-20-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salem Cemetery

18. (a) Signature of funeral director Alvin W. Hood

(b) Address 303 E. 1st St. Dealey, Mo.

19. (a) 9-20-45 (b) Esther Rudloff  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 17  
year 1945 hour 3 minute 50 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death coroner jury verdict: unrepairable accident signed by 5 of 6 jurymen

Due to \_\_\_\_\_

Due to crushed skull ✓

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

**PHYSICIAN** \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident **94**

(b) Date of occurrence Sept. 17, 1945

(c) Where did injury occur? Dealey, St. Francois Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public highway #32

While at work? No (Specify type of place) (e) Means of injury crushed skull

23. Signature Carl J. Miller **2** Carver  
(M. D. or other) **2**

Address Farmington, Mo. Date signed 9/18/45

RECEIVED

District Health Officer No. 4  
District File Number 1045-119  
Date Filed 10-9-45

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.....

....., Registered Apprentice No.....

..... working under my personal supervision.

Signed.....

*Alvin W. Hood*

Licensed Embalmer No. 2780

P. O. Address 303 Crane St. Flat (Rm.)

**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 this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. oct

Registration District No. 316

Primary Registration District No. 6074

Registrar's No. 160

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town DeSloge Randolph Twp  
(c) Name of hospital or institution  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community years, months or days

3. (a) PRINT FULL NAME Nelda L. Keel

3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive

7. Birth date of deceased Jan 27  
(Month) (Day) (Year)

8. AGE: Years 6 Months 7 Days 20 If less than one day min.

9. Birthplace Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County  
(c) City or town (If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1945 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from 9 to 10 1945; that I first saw him alive on 9 1945; and that death occurred on the date and hour stated above. Immediate cause of death

Due to accident caused when truck ran over pedestrian  
child was crossing highway

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations  
Of autopsy  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 10/12

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident  
(b) Date of occurrence Sept. 17, 1945  
(c) Where did injury occur? DeSloge St. Francois Mo.  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway #32 (Mo. State Highway)  
While at work? no (e) Means of injury struck head  
23. Signature Beryl Miller (M.D. or other) garner  
Address Farmington, Mo Date signed 9/18/45

SUPPLEMENTARY

313ldp

Dr. J. Muller  
C. J. Muller  
E. J. Muller