

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 20 1942

Registration District No. 799Primary Registration District No. 6024 ARegistrar's No. 4

1. PLACE OF DEATH:

- (a) County St. Francois
 (b) City or town Desloge, Mo RAVENS
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 1 V

(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

3. (a) PRINT FULL NAME

Mr. William Hardy Keel

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex

M

5. Color or race

W

6. (a) Single, widowed, married,

divorced married

6. (b) Name of husband or wife

Mrs. Marika L. Keel

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased

January 8 1891
(Month) (Day) (Year)

8. AGE:

Years

82

Months

10

Days

4

If less than one day

____ hr. _____ min.

9. Birthplace

Perry Co. near St. Marys
(City, town, or county) (State or foreign country)

10. Usual occupation

retired farmer

11. Industry or business

12. Name

Mr. Fredrick Keel

13. Birthplace

unknown
(City, town, or county) (State or foreign country)

14. Maiden name

Elizabeth McWilliams
(City, town, or county) (State or foreign country)

15. Birthplace

unknown
(City, town, or county) (State or foreign country)

16. (a) Informant

Mrs. E. J. Heck - daughter

(b) Address

Desloge, Mo

17. (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

3-7-42
(Month) (Day) (Year)

(c) Place: burial or cremation

Salem Chapel

18. (a) Signature of funeral director

Alvin W. Heck

(b) Address

303 Crane St. - Old River, Mo.

19. (a)

3-7-42
(Date received local registrar)

(b)

Byrde S. Bukhmerster
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State
- Desloge, Mo
- (b) County
- St. Francois

- (c) City or town
- mo
- (If outside city or town limits, write "RURAL")

- (d) Street No.
- 303
- (If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- March
- day
- 4
- 19
- 42
-
- year
- 1942
- hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from
- July 13 42
-
- March 2
- 19
- 42
- to
- March 3
- 19
- 42

that I last saw alive on March 3 1942
and that death occurred on the date and hour stated above.

Immediate cause of death

Chronic myocardi
Senescent Arteriosclerosis

Duration

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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

- (a) Accident, suicide, or homicide (specify) _____
-
- (b) Date of occurrence _____
-
- (c) Where did injury occur? _____ (City or town) (County) (State)
-
- (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
e) Means of injury _____

23. Signature
- R. Applegate
- (M. D. or other) _____
-
- Address
- Desloge, Mo
- Date signed
- 3-7-42

1176 (Licensed Embalmer's Statement on Reverse Side)

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

4
0
0

RECEIVED

District Health Officer No. 4

District File Number 442-40

Date Filed 4-9-42

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 MBA

Licensed Embalmer No. 2780

P. O. Address 303 Crane St.

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. 118 50

Registration District No. 779

Primary Registration District No. 6024a

Registrar's No.

1. PLACE OF DEATH:

(a) County St Francis

(b) City or town Rural
(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 MO (b) County St Francis

(c) City or town Deerlog
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William H Keel

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day _____ year 1949 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I have seen him _____ live on _____ 19____; and that death occurred on the date and hour stated above.

4. Sex m 5. Color or race white 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased: Jan 8 - 1901
(Month) (Day) (Year)

Immediate cause of death: Cor. myocarditis, Arteriosclerosis

8. AGE: Years 82 Months 11 Days 16 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 3-7-42 (b) Byrdie Bukhmaster
(Date received local registrar) (Registrar's signature)

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed 11/8

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

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11850