

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 384

Primary Registration District No. 4227

Registrar's No. _____

1. PLACE OF DEATH:

(a) County HOWELL

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

(c) Name of hospital or institution: CHRISTA HOGAN HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 DAYS
(Specify whether years, months or days)

In this community 95 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HOWELL

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

(d) Street No. 23 SUMMIT ST.
(If rural, give location)

(e) If foreign born, how long in U. S. A. 0 years.

8. (a) PRINT FULL NAME EFFIE KELLETT WILBUR

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE

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

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

7. Birth date of deceased SEPTEMBER 9, 1874
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 18, year 1941 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from March 15, 1941 to March 18, 1941; that I last saw her alive on March 18, 1941; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

<u>66</u>	<u>6</u>	<u>9</u>	hr. _____ min. _____
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9. Birthplace UDALL, OZARK CO, MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

Immediate cause of death Pneumonia

Due to _____

Due to _____

Other condition Concomitant of pneumonia
(Include pregnancy within 3 months of death)

11. Industry or business _____

MOTHER FATHER

12. Name FRANK M. KELLETT

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

14. Maiden name ALICE ESTELLA CONKIN

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

Major findings: Of operations _____

Of autopsy None

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Francis R. Wilbur

(b) Address WEST PLAINS, Mo. 23 SUMMIT ST

17. (a) BURIAL (b) Date thereof MAR. 20, 1941
(Burial, cremation, or removal) OAK LAWN CEM. (Month) (Day) (Year)

(c) Place: burial or cremation WEST PLAINS, Mo.

18. (a) Signature of funeral director Hal Thomburgh

(b) Address WEST PLAINS, Mo.

19. (a) 3/20/41 (b) Vida W. SIMONS
(Date received local registrar) (Registrar's signature)

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 places, in public places? 344

(e) Means of injury _____
(Specify type of place)

28. Signature W. Hogan (Specify type of place) _____
While at work? (e) Means of injury

Address West Plains, Mo Date signed 3/27/41

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 5,

District File Number 44/475

Date Filed _____

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 Hal Thompson

Licensed Embalmer No. 3408

P. O. Address West Plains, Mo.

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, above space should be left blank.