No. 2
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3390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 25 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21365

Registration District No. 384 Primary Registration District No. 4227 Registrar's No.

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

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: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 7 wks (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Howell
(c) City or town ~~West Plains~~ Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Gainesville Route West Plains
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ronald James Keith
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 Infant
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 10/10-41 (Month) (Day) (Year)
8. AGE: Years | Months 7 wks | Days | If less than one day hr. min.
9. Birthplace West Plains (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Infant
11. Industry or business
MOTHER FATHER
12. Name Alvis Keith
13. Birthplace Ozark Co. (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name Prentice Butler
15. Birthplace New Bern (City, town, or county) Mo (State or foreign country)
16. (a) Informant Alvis Keith
(b) Address West Plains Mo
17. (a) B. (Burial, cremation, or removal) (b) Date thereof 12-4-41 (Month) (Day) (Year)
(c) Place: burial or cremation Mitry Cem, Mo
18. (a) Signature of funeral director Roberts Inc
(b) Address West Plains, Mo
19. (a) 12-12-41 (Date received local registrar) (b) Vida W. Simons (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 3 year 1941 hour 9 minute 15 P.M.
21. I hereby certify that I attended the deceased from 11/29 1941 to 12/3/ 1941 that I last saw him alive on 11/30 1941 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Bronchial Pneumonia ✓
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 statistically.

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)
While at work? (e) Means of injury
23. Signature A. H. Thornburgh (M. D. or other) M. D.
Address West Plains, Missouri Date signed 12/5/41

1125 (Licensed Embalmer's Statement on Reverse Side) Thornburgh

RECEIVED
District Health Officer No. 5,
District File Number 442226-
Date Filed 7-20-42

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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

S. No. 2B
T—8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21 365

Registration District No. 384 Primary Registration District No. 4227 Registrar's No.

SUPPLEMENTARY

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Ronald J. Routh
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: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Oct (Month) 10 (Day) 1941 (Year)
8. AGE: Years | Months: 7 wks. | Days | If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day year 1941 hour minute M.
21. I hereby certify that I attended the deceased from Nov. 29, 1941 to Dec. 3, 1941 that I last saw him alive on Nov. 29, 1941 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchial Pneumonia	
Due to: No complications.	
Due to: N.M.O.	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 107	
Of autopsy	

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)
(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)
While at work? (e) Means of injury

23. Signature: A. H. Thomburgh (M. D. or other) M.D.
Address: West Plains, Mo. Date signed: 8/12/42