

No. 2
-8-13
5-17-39
X37823

State File No. _____

FILED NOV 28 1944

Primary Registration District No. 1000

Registrar's No. 1168

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1719 Messanie Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none
(Specify whether)

In this community Sixty odd yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph 11
(If outside city or town limits, write "RURAL")

(d) Street No. 1719 Messanie
(If rural, give location)

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

3. (a) PRINT FULL NAME Sarah Keaton

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16
year 1944 hour 10 minute 50 A.M.

21. I hereby certify that I attended the deceased from
7 Sept 1944 to 16 Nov 44
that I last saw her alive on 16 Nov 1944
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife William Keaton 6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased _____
(Month) (Day) (Year)

Immediate cause of death Heart Hemorrhage ✓

Due to Senility

Duration 1 Day

8. AGE: 83 Years Months 0 Days 2
If less than one day hr. _____ min. _____

9. Birthplace Nashville Ten 1
(City, town, or county) (State or foreign country)

10. Usual occupation House Keeper

11. Industry or business none

12. Name unknown

13. Birthplace unknown 7
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Keaton

15. Birthplace unknown 1
(City, town, or county) (State or foreign country)

16. (a) Informant William Keaton Jr

(b) Address 1719 Messanie

17. (a) burial (b) Date thereof Nov. 19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Center

18. (a) Signature of funeral director Raymond L. Soyars

(b) Address 1607 Messanie St.

19. (a) 11-18-44 (b) Edwin J. Tickle
(Data received local registrar) (Registrar's signature)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Other conditions _____

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? _____

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

23. Signature Raymond L. Soyars (M. D. or other) _____

Address St. Joseph Mo. Date signed 18 Nov 44

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

MOTHER FATHER

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, ~~of~~

Registered Apprentice No.

working under my personal supervision.

Signed

J. F. Ramsey

Licensed Embalmer No. *4081*

P. O. Address

St. Joseph

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.

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(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

3. (a) PRINT FULL NAME Sarah Keaton
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased nm 14 1906
(Month) (Day) (Year)

8. AGE: Years 83 Months _____ 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) _____ (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) _____ (b) _____
(Data 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 Nov day 26
year 1984 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chalk Mountain
Cancer of Palate
and Adenya Duration 3 mo

Due to _____
Due to 450
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION

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? _____

While at work _____ (Specify type of place)
Means of injury _____
23. Signature E. J. Stearns (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY INFORMATION

37218