

No. 2
-12-45
5-17-39
I X4770

FILED MAR 25 1947
Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 108

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution:
St. Elizabeth Hospital 0
(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 _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 64

(c) City or town Hannibal 3
(If outside city or town limits, write "RURAL")

(d) Street No. 3301 Market 4
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME Charles H. O'Keefe

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12
year 1947 hour 7:00A.M. minute _____ M.

21. I hereby certify that I attended the deceased from 1-17-47
1 to 3-12-47, 19____, to 3-12-47, 19____;
that I last saw him alive on 3-12-47, 19____;
and that death occurred on the date and hour stated above.

4. Sex Male 0 5. Color or race White

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

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

7. Birth date of deceased May 5 1866
(Month) (Day) (Year)

Immediate cause of death	Duration
<u>coronary sclerosis; damaged myocardium</u>	<u>6 mo.</u>
<u>hypertrophied prostate</u>	<u>2 yrs</u>
<u>urinary tract infection</u>	<u>several yrs</u>
<u>general debility</u>	

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

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

<u>80</u>	<u>10</u>	<u>7</u>	_____ hr. _____ min.
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9. Birthplace Spalding Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer (retired)

11. Industry or business _____

12. Name Daniel O'Keefe

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

14. Maiden name Catherine Garland

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Ben O'Keefe

(b) Address New London, Mo.

17. (a) Burial (b) Date thereof 3-14-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brush Creek Cemetery

18. (a) Signature of funeral director J. J. Callanell Rolla, Mo.

(b) Address Hannibal, Mo.

19. (a) 3/17/47 (b) W. M. Lucke
(Date received local registrar) (Registrar's signature)

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

(c) 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 J. J. Buttman (M. D. or R.C.) MD

Address 115 N. 5th St., Hannibal, Mo. Date signed 3-14-47

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, or by.....

....., Registered Apprentice No. 497

working under my personal supervision.

Signed..... H. M. O'Donnell

Licensed Embalmer No. 3889

P. O. Address..... Harvard 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, fact should be so stated above.