

Registration District No. 298

Primary Registration District No. 6023

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ray co
(b) City or town Polo Rural Knoxville
(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 all his life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County RAY
(c) City or town RURAL
(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 Mary J. McKee

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

4. Sex Female 5. Color or race wh
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Wm. B. McKee
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 7 1859
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 9 25 hr. _____ min.

9. Birthplace Ray co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER
12. Name Isaac Zimmerman
13. Birthplace Tenn
(City, town, or county) (State or foreign country)
14. Maiden name Ann Thompson
15. Birthplace Ray co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Max McKee
(b) Address Polo Mo

17. (a) Burial (b) Date thereof 3 5-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cougill Mo

18. (a) Signature of funeral director Chas. Crowly
(b) Address Polo Mo

19. (a) Mar 14 1947 (b) Mrs. Raymond Keane
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3
year 1947 hour 10 minute 30 P.M.
21. I hereby certify that I attended the deceased from Jan 2 - 1947
to March 3 1947
that I last saw her alive on Feb 27 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Exhaustion Duration 3 days
Due to Senile Dementia 3 yrs

Due to Arteriosclerosis (long standing)

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

Major findings: Of operations _____ Of autopsy _____
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 C.H. Willis M.D. (M. D. or other)
Address Polo Mo Date signed 3-9-47

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

RECEIVED

District Health Officer No. 8,

District File Number

File No. filed 4-18-47

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 with the above constitutes grounds for revocation of license.)

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