

FILED NOV 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38110**

BIRTH NO. _____ REG. DIST. NO. **234** PRIMARY REG. DIST. NO. **5816** Registrar's No. **28**

1. PLACE OF DEATH a. COUNTY Morgan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Morgan	
b. CITY OR TOWN Atterville, Mo.		c. CITY OR TOWN Atterville, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4 miles South of Atterville		STREET ADDRESS (If rural, give location) 4 miles S of Atterville	

3. NAME OF DECEASED (Type or Print) VIRGINIA-ROSE-KEED			4. DATE OF DEATH (Month) (Day) (Year) Nov. 23, 1954		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 29, 1872	9. AGE (In years if under 1 year last birthday) Months Days Hours Min. 82 5 20 -
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY same	11. BIRTHPLACE (City and State or Foreign Country) Atterville, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Frank Arno	13b. MOTHER'S MAIDEN NAME Eliza Smith	14. NAME OF HUSBAND OR WIFE John Keed
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NO.	17. INFORMANT'S SIGNATURE OR NAME Mr. Nolan Keed	ADDRESS Little Rock, Ark.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) Arteriosclerotic Heart disease		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Nov 23, 1954**, to **Nov 23, 1954**, that I last saw the deceased alive on **Nov 23, 1954**, and that death occurred at **6:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) P. Siegel MD	23b. ADDRESS Smithson Mo	23c. DATE SIGNED 11-25-54
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Nov 26, 54	24c. NAME OF CEMETERY OR CREMATORY L.O.F. Cemetery	24d. LOCATION (City, town, or county) (State) Atterville Mo.
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DATE REC'D BY LOCAL REG. 11-27-54	REGISTRAR'S SIGNATURE Dr. M. L. Kappeler	25. FUNERAL DIRECTOR'S SIGNATURE Hays Painter	ADDRESS Pilot Grove, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Robert L. Paint*.....

Licensed Embalmer No. *406*

P. O. Address *Pilot St.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.