

FILED FEB 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2418

STATE FILE NUMBER

 Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>Ray</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond - rural</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Richmond</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 miles North Richmond</u> Length of stay in lb <u>80 years</u>		d. STREET ADDRESS (If outside, give location) <u>2 miles North Richmond</u> Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HORACE</u> Middle <u>C.</u> Last <u>KEYES</u>			4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1869</u>
9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>12</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>	11. BIRTHPLACE (City and state or country) <u>Richmond, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William C. Keyes</u>	
14. MOTHER'S MAIDEN NAME <u>Lucy Ann Jackson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Forrest B. Thompson, Richmond, Missouri</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4/201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>unknown</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a. m. <u></u> p. m. <u></u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>April 4, 1956</u> to <u>Jan. 29, 1957</u> and last saw <input checked="" type="checkbox"/> him alive on <u>Jan. 18, 1957</u> . Death occurred at <u>3:15 PM</u> on the date stated above; and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. C. Johnson, M.D.</u>		22b. ADDRESS <u>Richmond, Mo.</u>	
22c. DATE SIGNED <u>1/30/57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>January 31, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>many flow cemetery</u>	
23d. LOCATION (City, town, or county) <u>Richmond Missouri</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>WEST-LIFE FUNERAL HOME</u> ADDRESS <u>RICHMOND, MISSOURI</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 30-1957</u>	
26. REGISTRAR'S SIGNATURE <u>Malcolm Jackson</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with or without. All

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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 *Joseph H. Hill*.....
Licensed Embalmer No. 404

P. O. Address *Retired*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.