N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Scott

Township: Sylvania
or
Village:
or
City: (NO. St.; Ward)

Registration District No.: 820

Primary Registration District No.: 6069

File No.: 41104

Registered No.: 85

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Donald Cline Keith

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	At home

DATE OF BIRTH: June (Month) 1 (Day), 1914 (Year)

AGE: yrs. 9 mos. 25 ds. — If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): At home

BIRTHPLACE (City or town, State or foreign country): Oran Mo

PARENTS
- NAME OF FATHER: Dennis Keith
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
- MAIDEN NAME OF MOTHER: Ada Webb
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bert Hance

(ADDRESS) Oran Mo

Filed 12/31, 1914. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov (Month) 25 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 25, 1914, to Nov 25, 1914, that I last saw him alive on Nov 25, 1914, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(Duration) yrs. mos. 9 ds.

Contributory (Secondary) Meningitis (Duration) yrs. mos. 1 ds.

(Signed) W H Wescott M. D.

Nov 25, 1914 (Address) Oran Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Oran Mo	Nov 26, 1914
UNDERTAKER	**ADDRESS**
T. S. Hemmer	Oran Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*..... (Month) (Day) (Year)

AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ...., 191..., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory
(SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.