

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

20769

1. PLACE OF DEATH

County Jackson Registration District No. _____ File No. 20928
 Township Tow Primary Registration District No. 430 Registered No. _____
 City Kansas City (No. Old City Hospital) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 214 Greely S.C. St. St. _____ Ward. Kansas City, Kansas
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 10, 1903

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>18</u>	<u>2</u>	<u>2</u>	<u>16</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) Common Labor
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Louisiana

10. NAME OF FATHER William Keys

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Louisiana

12. MAIDEN NAME OF MOTHER Jarvis Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Louisiana

14. INFORMANT Marshall Keys (Address) 214 Greely S.C. St.

15. FILED 8/29 1921 M. M. Cross REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 26 1921

17. I HEREBY CERTIFY, That I attended deceased from Aug 23, 1921, to Aug 26, 1921, that I last saw him alive on Aug 26, 1921, and that death occurred, on the date stated above, at 5:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Typhoid Fever

CONTRIBUTORY (SECONDARY) (Hyperthermia)
Pyrexia (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED Don't know
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____ (Signed) J. Thompson, M. D.

26, 1921 (Address) Old City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wheeler Springs, Ark. DATE OF BURIAL Sept 1 1921

20. UNDERTAKER Adkins Bros. ADDRESS K.C. Mo

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

