

APR 25 1927

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

Do not use this space.

7848

1. PLACE OF DEATH  
County Greene Registration District No. 318  
Township Springfield Primary Registration District No. 2001  
City Springfield (No. 150) St. W. Lyon Registered No. 197  
St. \_\_\_\_\_ Ward \_\_\_\_\_  
2. FULL NAME Mrs. J. M. Kee  
(a) Residence. No. 1807 W. Lyon St. \_\_\_\_\_ Ward \_\_\_\_\_  
(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

SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (mar)  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 1853  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
73 6 7  
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).  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Tenn.  
(STATE OR COUNTRY)

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Jessie M. Kee  
(Address) Springfield, Mo.

15. FILED Apr 27 1927 October 1929  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/26 1927

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 1927, to \_\_\_\_\_, 1927, that I last saw him alive on 3/23/27, 1927, and that death occurred, on the date stated above, at \_\_\_\_\_, m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Voluntary heart disease  
9/10/27 (duration) 3 yrs. — mos. — da.  
CONTRIBUTORY (SECONDARY) Cerebral  
(duration) — yrs. — mos. 10 da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) J. J. [Signature], M. D.  
3/26, 1927 (Address) Springfield

\*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Green Lawn Cemetery Mar 27 1927

20. UNDERTAKER K. W. [Signature] ADDRESS Springfield, Mo.

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.

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