

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

Do not use this space.

18508

1. PLACE OF DEATH

County Jackson
Township New
City Keosauqua

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 2510
St. _____ Ward _____

2. FULL NAME

(a) Residence No. Historia, Mo. St. _____ Ward _____

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept-8-1858

| | | | | |
|--------|-----------|----------|-----------|--|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, _____ hrs. or _____ min. |
| | <u>68</u> | <u>9</u> | <u>21</u> | |

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER

Chas. Reed

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER

no Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) no Record

14.

INFORMANT Mrs. P. W. Jones
(Address) 480 Blue Ridge Blvd

15.

FILED 6/29, 27 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4 **16. DATE OF DEATH (MONTH, DAY AND YEAR)** June 29 27

17. I HEREBY CERTIFY That I attended deceased from 6-16 1927 to 6-29 1927
that I last saw him alive on 6-28 1927, and that death occurred, on the date stated above, at 6-2846 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Cholecystitis
& Hepatitis

CONTRIBUTORY Gall Stones (duration) 3 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Her Res.

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 6-28-27

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? History of Operation

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

4/29, 1927 (Address) 879 North Bldg

*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

Historia Mo

6/30/27

20. UNDERTAKER

ADDRESS

Mrs. C. L. Foster 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.

