

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

Do not use this space.

21371

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kan Primary Registration District No. 1002 Registered No. 82716
 City Keokuk (No. Industrial Hospital St. _____ Ward)

2. FULL NAME

William Frank Treff
 (a) Residence. No. 1002 Newton Ave 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

3. SEX Male 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 5, 27

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 7 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Keokuk Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER William Treff

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

12. MAIDEN NAME OF MOTHER May-Rose

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

14. INFORMANT William Treff
 (Address) 1002 Newton Ave

15. FILED 7/8 '27 M. M. Green Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 6 1927

17. I HEREBY CERTIFY, That I attended deceased from July 5 - 7 1927
 that I last saw h. _____ alive on July 6 1927 and that death occurred, on the date stated above, at 7:20 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Chlorosis
15 yrs (duration) yrs. mos. 6 mos
 CONTRIBUTORY Pneumonia 8 months
 (SECONDARY) 16/10 (duration) yrs. mos. da.

18. WHERE WAS DEATH CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) E. N. Martin M. D.
7/7 1927 (Address) 6500 Wash Ph 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 Germany Cem. DATE OF BURIAL 7-7 1927

20. UNDERTAKER Mrs C. L. Foster ADDRESS 918 Brooklyn

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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