

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

Do not use this space.

27459

1. PLACE OF DEATH

County Jackson
Township Franklin
City Keosauqua

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. _____
Ward) _____

2. FULL NAME

(a) Residence. No. 1833 Houston Ave 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 13 - 1864

7. AGE YEARS Months Days If LESS than 1 day, ____ hrs. or ____ min.
63 | 3 | 16

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Real Estate
(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) Mo

10. NAME OF FATHER James Battles

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

12. MAIDEN NAME OF MOTHER no record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no record

14. INFORMANT Mrs Mary A Battles
(Address) 1833 Houston Ave

15. FILED 10-1, 1927 M. M. Crowe
deet REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic nephritis
131
170 R (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH... 124

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Chemical & laboratory
(Signed) [Signature], M. D.
9/30, 1927 (Address) 1814 Med Auto City

*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 Chenwood DATE OF BURIAL Oct 13 1927

20. UNDERTAKER Mrs C. L. Foster ADDRESS Keosauqua

WRITE FULLY, WITH UNFADING INK, WITH UNFADING INK, WITH UNFADING INK

X. 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.

1017 Med Auto Bldg
Hp 95-45

U.S. MAIL