CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

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

Do not use this space.

29463

1. PLACE OF DEATH

County Audrain — Registration District No. 951 — File No.

Township Wilson — Primary Registration District No. 5037B — Registered No. 6

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Margie Ann Keeton

(a) Residence. No. ..... 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. 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): Widdow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: William Keeton - Deceased

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct-13-1848

7. AGE: 79 Years — Months — Days 12 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Keeper 92

(b) General nature of industry, business, or establishment in which employed (or employer): 111

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Calloway Co Mo

PARENTS

10. NAME OF FATHER: Henger Willett

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

12. MAIDEN NAME OF MOTHER: Saville Russell

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

14. INFORMANT: W. T. Keeton
(Address): Thompson Mo

15. FILED Oct 26, 1927 — [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 25 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 13, 1927, to Oct 25, 1927, that I last saw her alive on Oct 24, 1927, and that death occurred, on the date stated above, at 11 30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

~~Passive Pneumonia~~

Chronic Myocarditis

(duration) Several yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Hypostatic Pneumonia

(duration) yrs. mos. 6 ds.

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) Robt W Berry, M. D

, 19 (Address) Mexico Mo

*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: Saltriver Church Cem Mo — DATE OF BURIAL: 10-27 1927

20. UNDERTAKER: H A Brecht & Son — ADDRESS: Mexico Mo

1827
79
48

25
13
12

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1. PLACE OF DEATH

County: Andrain — Registration District No.: 951 — File No.:

Township: Wilson — Primary Registration District No.: 5037B — Registered No.:

City: (No. , St. Ward)

2. FULL NAME Margie Ann Kieton

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	W

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

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

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

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT
(Address)

15. Filed Jan. 9, 1928 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 25 1927

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19, that I last saw h alive on 19, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
Chronic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) [redacted]

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 908
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Robt W Berry, M. D
, 19 (Address) Mufio Mo.

*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 19
20. UNDERTAKER	ADDRESS

S-29463