LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

JAN 20 1928

37847

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

PLACE OF DEATH: County: Polk; Township: Johnson; City: ..... (No. ..... St. ..... Ward)

Registration District No. 703; Primary Registration District No. 4427 5922; File No. #E 14; Registered No. ....

FULL NAME: ~~Etta May~~ Elda Mae Kire

(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.

V. S. No. 2.

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.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

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

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Single

DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 17-1925

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2		10	

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

BIRTHPLACE (CITY OR TOWN): Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER: Arnold Kire

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

12. MAIDEN NAME OF MOTHER: ~~Estoby~~ Mildred.

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

INFORMANT: Ralph Joseph
(Address): Bunceton Mo

FILED 12/27, 1927 C N Hahn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec. 27 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1927, to Dec 27, 1927, that I last saw he alive on Dec 27, 1927, and that death occurred, on the date stated above, at 7A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gastro Enteritis
120B
(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... 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) C N Hahn, M. D
, 19 (Address) Bunceton 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Pleasant Ridge — DATE OF BURIAL: 12-28 1927

20. UNDERTAKER: St Joseph. — ADDRESS: Bunceton

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....,..... .....St. .....Wa

2. FULL NAME .....

(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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..... 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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I HEREBY CERTIFY, That I attended deceased from .....
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death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....,
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, s
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL
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19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURI
20. UNDERTAKER	ADDRESS