

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

Do not use this space 2123

1. PLACE OF DEATH
 County Pike Registration District No. 689
 Township Buffalo Primary Registration District No. 5917
 City Elmwood Sch dist (No. Elmwood Sch dist)
 Registered No. _____ St. _____ Ward) _____

2. FULL NAME Kenith Earl Travis
 (a) Residence No. Elmwood Sch dist (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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-4-1927

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	—	11	22	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Infant
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Buffalo Twp
 (STATE OR COUNTRY) Pike Co Mo

10. NAME OF FATHER Wade Travis

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

12. MAIDEN NAME OF MOTHER Nora Pozier

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Pike Co Mo

14. INFORMANT Wade Travis
 (Address) Road # 2 Louisiana Mo

15. FILED 427 1928 FOKNEY
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-25-28 1928

17. I HEREBY CERTIFY, That I attended deceased from 2-4-1927 to 4-25-28, 1928 that I last saw him alive on 4-26, 1928, and that death occurred, on the date stated above, at 3:30 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Enterocolitis
113B (duration) yrs. mos. 7 ds.
 CONTRIBUTORY (SECONDARY) 113B (duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED THE POSITIVE? _____
 (Signed) M Crewdson, M. D.
427, 1928 (Address) Louisiana 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 Louisiana Pike Co Mo DATE OF BURIAL 427 1928

20. UNDERTAKER JC Naugh ADDRESS Louisiana Mo

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.

