

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

Do not use this space.

32754

1. PLACE OF DEATH
 County Bachman Registration District No. 105 File No. _____
 Township _____ Primary Registration District No. _____ Registered No. 1148
 City St. Joseph (No. Missey Hospital) St. _____ Ward _____

2. FULL NAME Amabel Edith Keys
 (a) Residence. No. St. Joseph _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OF (OR) WIFE OF R. N. Keys

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 3, 1888

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>42</u>	<u>9</u>	<u>28</u>	

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

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

10. NAME OF FATHER James West

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

12. MAIDEN NAME OF MOTHER Madeline Roberts

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

14. INFORMANT R. N. Keys
 (Address) St. Joseph

15. FILED 1928 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 1, 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1928, to Oct 1, 1928 that I last saw him alive on Oct 1, 1928, and that death occurred, on the date stated above, at 11:30 - a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Valvular & cellular +
degenerative changes
General peritonitis. 1225
 (duration) yrs. 123 mos. 14 ds.

CONTRIBUTORY (SECONDARY) 118 B1
 (duration) yrs. _____ mos. _____ ds.

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

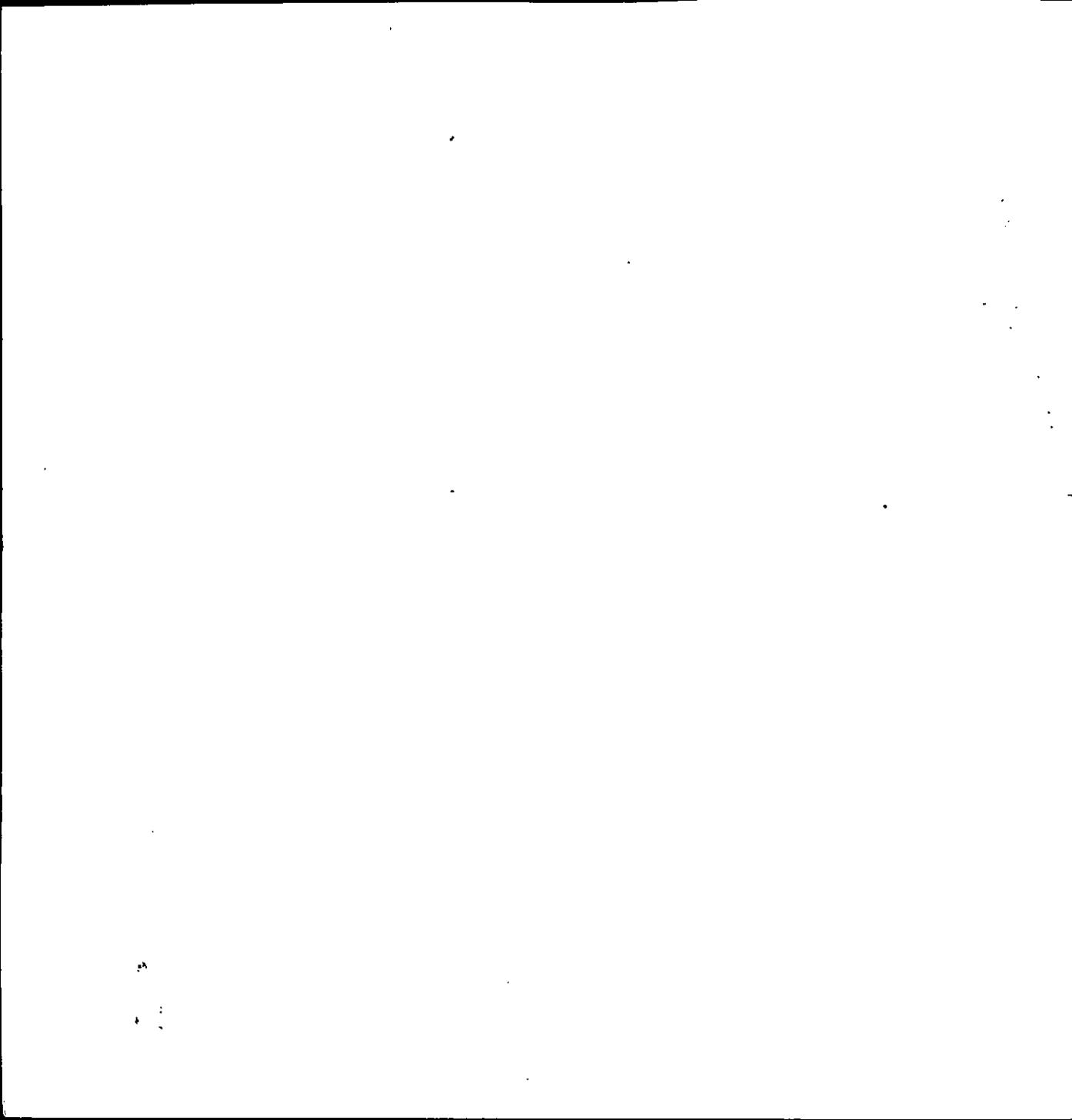
19. DID AN OPERATION PRECEDE DEATH? yes DATE OF Sept 29 1928
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Findings
 (Signed) J. P. Walker, M. D.
 (Address) Missey Hospital

*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 St. Joseph Mo. DATE OF BURIAL 10-5-1928

20. UNDERTAKER R. S. Taggart ADDRESS St. Joseph



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF BIRTH.

County DeKalb Registration District No. 85 File No. 1148
 Township St Joe Primary Registration District No. 1001 Registered No. 1148
 City St Joe (No.) St. Ward)

2. FULL NAME

Mabel Edith Keys
 (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 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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.
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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)

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 11-26-28 John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 1 1928

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and 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:

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

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

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)....., M. D. , 19 (Address)

*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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

S-32754