

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

Do not use this space.

Sulyr 41681

File No. _____
 Registered No. *33H* _____
 St. _____ Ward) _____

JAN 24 1928

1. PLACE OF DEATH

County *Marion* Registration District No. *547*
 Township *Marion* Primary Registration District No. *3079*
 City *Hannibal* (No. *2523* *Chestnut st*)

2. FULL NAME

William B Keck
 (a) Residence. No. *2523 Chestnut* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED *WIFE OF John M Keck*
 (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 18 1887*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
51 3 20 =
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *House Wife*
 (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) *Marion Co Mo*

10. NAME OF FATHER *Wm F Brown*

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

12. MAIDEN NAME OF MOTHER *Anna E Baxter*

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

14. INFORMANT *Mr. Eva Turner*
 (Address) *Hannibal Mo.*

15. FILED *12/19 1928* *Castro* # REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 18 1928*
 17. I HEREBY CERTIFY, That I attended deceased from *Dec 19 1928*, to *Dec 18 1928*, and that I last saw her alive on _____, 19____, and that death occurred, on the date stated above, at *5:00 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
 (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY)

flu
 (duration) _____ yrs. _____ mos. _____ da.

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) *Stalger* M. D.
 , 19 (Address) *Hannibal 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 *Providence Cem.* DATE OF BURIAL *12/20 1928*

20. UNDERTAKER *Wm M Smith* ADDRESS *Hannibal*

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.

