

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

Do not use this space.

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**1. PLACE OF DEATH**

County..... Andrew ..... Registration District No. .... 10 ..... File No. ....  
 Township..... Monroe ..... Primary Registration District No. .... 3-0-1-3 ..... Registered No. .... 1 .....  
 City..... (No. 3 Miles West of Cosby, Mo.) ..... St. .... Ward .....

**2. FULL NAME**

~~XXXXXXXX~~ Beverly Jeane Kieser  
 (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 1 yrs. mos. da. 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov, 7, 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
1 1 28

**8. 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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Joseph, Mo.

PARENTS

10. NAME OF FATHER John Roy Kieser

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

12. MAIDEN NAME OF MOTHER Iva Thomas

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

14. INFORMANT John R. Kieser  
 (Address) Cosby, Mo.

15. FILED Jan 6, 1929 B. L. Allen REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan, 5, 1929 19

17. I HEREBY CERTIFY That I attended deceased from Dec 26, 1928 to Dec 26, 1928 that I last saw her alive on Dec 26, 1928, and that death occurred, on the date stated above, at 10 P. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Bronchial Pneumonia  
107A (duration) yrs. mos. 11 da.

CONTRIBUTORY (SECONDARY) (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.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) B. L. Allen, M. D.

Jan. 6, 1929 (Address) Cosby 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 Memorial Park Cemetery DATE OF BURIAL Jan, 6, 1929

20. UNDERTAKER Walter Nischoffe ADDRESS St. Joseph, 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.

1929  
200

[The main body of the page is mostly blank with some faint, illegible markings and noise.]

This Baby was treated by  
Christian Science except I  
made one call as stated on  
certificate.

*B L Allen*

1929 # 36

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Andrew  
Township Monroe  
City..... (No.....)..... St..... Ward.....

Registration District No. 10  
Primary Registration District No. 5013

File No.....  
Registered No. 1  
St..... Ward.....

**2. FULL NAME**

Beverly Jeanne Kiesen

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (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 day, or

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work..... (duration) yrs. mos. ds.  
(b) General nature of industry, business, or establishment in which employed (or employer)..... (duration) yrs. mos. ds.  
(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

Jan 7 1929

B.L. Allen

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 19 29

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

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Bronchial pneumonia

**NOTARY PUBLIC**  
**SUPPLEMENTARY**

CONTRACTED

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

19

20. UNDERTAKER

ADDRESS

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

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