

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

Do not use this space.

1393

1. PLACE OF DEATH

County Jackson
Township Blue
City Independence (No. Sanitorium)

Registration District No. 398
Primary Registration District No. 3019

File No. _____
Registered No. 34
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1324 Maple 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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 6, 1851

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
77 2 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Clifton Park N.Y.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT R. T. Cooper
(Address) 1030 W. Waldo

15. FILED 2-2-29 F. L. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 3/1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1929, to Jan 31 1929
that I last saw her alive on Jan 31 1929, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho pneumonia
107A
69B

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) Obesity

(duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) John B. Wheeler, M. D.

2-2-29 (Address) Independence 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 Mound Grove DATE OF BURIAL 2-3 1929

20. UNDERTAKER J. L. Latta, Ind. Mo. 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.

WRITE IN PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD

2 1929
48
9
8
238
2
31
31

