23 1929
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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

3121

1. PLACE OF DEATH

County: Ray county — Registration District No.: 915 — File No.:

Township: Knoxville — Primary Registration District No.: 6236 — Registered No.: 1

City: (No. ..., ... St. ..... Ward)

2. FULL NAME Mount Vernon Keene

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
Male	white	single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 28. 1910

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	18	—	6	

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) Ray Co.

PARENTS

10. NAME OF FATHER Grafton Keene

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

12. MAIDEN NAME OF MOTHER Sarah J. Cox

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

14. INFORMANT Grafton Keene (Address) Polo Mo.

15. FILED Jan 5, 1929 Mrs. G. W. Gaines REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929, to Jan 4, 1929, that I last saw him alive on Jan 4, 1929, and that death occurred, on the date stated above, at 9 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
Peri Carditis

11B
10B
CONTRIBUTORY (SECONDARY) 11B (duration) yrs. mos. 8 ds.
(duration) yrs. mos. ds.

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

0 DID AN OPERATION PRECEDE DEATH? no. DATE OF ✓

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) D. G. W. Gaines, M. D

Jan 5, 1929 (Address) Rayville, 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	DATE OF BURIAL
Bethel Cemetery	1-6 1929
20. UNDERTAKER	**ADDRESS**
Alspaugh & Howley	Polo

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.