

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

Do not use this space.

10260

1. PLACE OF DEATH

Green
City *Springfield Mo.*

Registration District No. *318*
Primary Registration District No. *2001*

File No.
Registered No. *217*
St. Ward)

2. FULL NAME

Alfred Marion Keesinger

(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

Male

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

Single

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

Sept 24th 1908

7. AGE

YEARS *20* MONTHS *5* DAYS *10*

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Famer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Missouri

(STATE OR COUNTRY)

10. NAME OF FATHER

John Keesinger

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Missouri

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Nancy Meper

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Missouri

(STATE OR COUNTRY)

14. INFORMANT

(Address)

*John Keesinger
Ozark Mo*

15. FILED

19 *3/7*

By O. H. St. Clair M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.

I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

(that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... *9:10 P*..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

VBH
31
(duration) *1* yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(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) *Sammy C. Stone* M. D.
, 19 (Address) *Springfield, 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

Prospect Cemetery

March 6 1929

20. UNDERTAKER

ADDRESS

T. B. Cheffin

Ozark, 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.

APR 24 1929

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