

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

Do not use this space.

10690

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township 1st Primary Registration District No. 1002
 City Hannas City (No. Hannas City Hannas Mo.) St. _____ Ward _____

File No. _____
 Registered No. 1197

2. FULL NAME

Keya H. James
 (a) Residence No. 3810 Perfect St. 13 Wafd. _____

(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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-7-1905

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
23 3 2

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Salesman
 (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) K. C. Mo.

10. NAME OF FATHER Walter Gas. Keys, Sr.
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Fork Becott, Mo.
 12. MAIDEN NAME OF MOTHER Stella Allen
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Perm

14. INFORMANT Reed Clark
 (Address) Hannas City Hannas Mo.

15. FILED 7/11 29 M. M. Crowder REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-9-1929

17. I HEREBY CERTIFY, That I attended deceased from 2-28- 1929, to 3-9- 1929 that I last saw him alive on 3-9- 1929, and that death occurred, on the date stated above, at 2:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Epidemic meningitis
18 (duration) yrs. mos. ds.
24 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) P. H. Williams, M. D.

3-10 1929 (Address) Supr. K. C. Hannas 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
Mr. Washington Feb. 11, 1929

20. UNDERTAKER ADDRESS
Mrs. L. K. Foster K. C. Mo.

WRITE FAIRLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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