

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

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1. PLACE OF DEATH
 23 1929 Buchanan
 Township St Joseph
 City St Joseph

Registration District No. 1001
 Primary Registration District No. 1001

File No. 443
 Registered No. 443
 (No. State Hospital for Insane #2 St. Ward)

2. FULL NAME Nettie Kiser
 (a) Residence. No. State Hosp St Joseph Mo St. Ward. Manassas Mo
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 3 yrs. 7 mos. 4 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>about</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>year 1880</u>		
7. AGE <u>49</u>	YEARS <u>2</u>	MONTHS <u>2</u>
	DAYS <u>2</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Nebraska

10. NAME OF FATHER C W Kiser

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. Informant State Hosp Records
 Address St Joseph Mo

15. FILED 1929 19 John G. Jtz REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 1, 1929
 17. I HEREBY CERTIFY, That I attended deceased from March 29, 1929, to April 1, 1929, and that I last saw her alive on April 1, 1929, and that death occurred, on the date stated above, at 5:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Erysipelas

(duration) yrs. mos. 10 da.
 CONTRIBUTORY None
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: at place of death

DID AN OPERATION PRECEDE DEATH? No DATE OF —

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Findings
 (Signed) J. H. Smith, M. D.
4/1, 1929 (Address) State Hosp #2

*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 Manassas, Mo DATE OF BURIAL April 4 1929

20. UNDERTAKER Heaton-Belale-Bowen ADDRESS 319 S. 10 St
Box 8, St. Joseph General Home



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Buchanan Registration District No. 835 File No. _____
 Township _____ Primary Registration District No. 1001 Registered No. 443
 City St Joe (No. _____) St. _____ Ward _____

2. FULL NAME

(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 1 day, _____ hrs. or _____ min.

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) _____

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 6/12/29 John E. W. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 1 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 _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Erysipelae
Abusing gas (cause not)
 (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 _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. P. Beach M. D.

, 19 29 (Address) State Hospital #2

*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 _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

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

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