MAY 29 1929

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

Do not use this space.

16965

1. PLACE OF DEATH
County Shelby
Township Jackson
City Hunnewell (No. ..... St. ..... Ward)
Registration District No. 828
Primary Registration District No. 4501
File No. .....
Registered No. .....

2. FULL NAME Kathleen M. Heskett
(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: Female
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: At Home.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 24 1895

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
24	2.	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Teacher
(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) Shelby Co Mo.

PARENTS
10. NAME OF FATHER Henry Heskett
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ill.
12. MAIDEN NAME OF MOTHER Mary Corbett
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Shelby Co Mo.

14. INFORMANT Mary Heskett
(Address) Hunnewell Mo.

15. FILED 4-5, 1929 R H Parker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from April 1st (4-1-28) 1928, to April 4, 1929 that I last saw h..... alive on April 3 1929, and that death occurred, on the date stated above, at 6 P.M. (6 PM RHP)

THE CAUSE OF DEATH* WAS AS FOLLOWS: Pulmonary Tuberculosis

23A

(duration) 1 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? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & X Ray
(Signed) R H Parker, M.D.
4-5, 1929 (Address) Hunnewell 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: Catholic Cem Hunnewell Mo.
DATE OF BURIAL: 4/8 1929

20. UNDERTAKER: Grover Givan
ADDRESS: Hunnewell 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD