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

Do not use this space.

68

1. PLACE OF DEATH
County Barry — Registration District No. 30 — File No.
Township — Primary Registration District No. 3003 — Registered No. 6
City Monett (No. ..... St. ..... Ward)

2. FULL NAME Chas W. Kenerston
(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 5 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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hannah M. Kenerston

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1 20 1930

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
82	8	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired, Doctor
(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) New Hampshire

PARENTS
10. NAME OF FATHER Chas Kenerston
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) New Hampshire
12. MAIDEN NAME OF MOTHER Lizzie Thompson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) New Hampshire

14. INFORMANT Wife Hannah M. Kenerston
(Address)

15. FILED ....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 20 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930 to Jan 20, 1930 that I last saw him alive on Jan 19, 1930, and that death occurred, on the date stated above, at 10 20 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhage of Stomach
(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Arterio-sclerosis
(duration) ? yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? at place of Death.
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Signs
(Signed) Ernest Mitchell, M. D
, 19 (Address) Monett 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: I.O.O.F. Cem.
DATE OF BURIAL: 1/22 1930

20. UNDERTAKER: H. J. Bradford
ADDRESS: Monett

AGE should be stated EXACTLY. PHYSICIANS should state classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County: Barry — Registration District No.: 30 — File No.:

Township: — Primary Registration District No.: 3003 — Registered No.: 6

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

2. FULL NAME: Chas W. Kenerston

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

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)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 3, 1847

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
82	8	11	

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)

PARENTS

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 ....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 20 1930

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:

Hemorrhage of Stomach
Gastric Ulcers
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Arteio sclerosis
..... (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) ....., M. D
, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

HW

REGISTRARS SHALL NOT RECEIVE A FEE UNTIL THEY ARE COMPLETE AS

5-68