

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Ray  
City Keokuk

Registration District No. 399  
Primary Registration District No. 1002  
(No. 1915 - Woodland)

File No. 5095  
Registered No. 753  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 1915 - Woodland 4 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 Co 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) 4-11-1926

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>3</u>	<u>10</u>	<u>7</u>	<u>7</u>	<u>7</u>

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Child  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Keokuk  
(STATE OR COUNTRY)

10. NAME OF FATHER Edd Mason

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

12. MAIDEN NAME OF MOTHER Anna Mayfield

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

14. INFORMANT Anna Mason  
(Address) 1915 Woodland

15. FILED 7/18 1930 M. M. Grove  
Ass REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb-18 1930

17. I HEREBY CERTIFY That I attended deceased from 2 18 1930 to 3 18 1930  
that I last saw him alive on 2 30 1930 and that death occurred, on the date stated above, at 430 - A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS: Cerebro spinal meningitis

CONTRIBUTORY (SECONDARY) 710 yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH. no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) C. V. Miller, M. D.

7/18, 19 30 (Address) 1426 E 18

\*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 West Lawn Cemetery DATE OF BURIAL Feb 19 1930

20. UNDERTAKER West Appleton + Jones ADDRESS 1500 E 17

