

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

Do not use this space *Chapman*

APR 30 1930

9554

1. PLACE OF DEATH
 County Missouri Registration District No. 526
 Township Springfield Primary Registration District No. 3030
 City Charleston (No.) St. Ward
 2. FULL NAME Thable C. Keith
 (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 50 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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 14 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
57 | 1 | 5

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work At Home
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER John Hart

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

12. MAIDEN NAME OF MOTHER Elizabeth Boyce

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

14. INFORMANT J. M. Hart
 (Address) Charleston Mo

15. Mar 20 1930 P. D. Vernon
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/19 1930 8:45 P.M.

17. I HEREBY CERTIFY That I attended deceased from JAN 28 1930 to MARCH 18 1930 that I last saw HER alive on MARCH 19, 1930, and that death occurred, on the date stated above, at 8:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
BRONCHIAL PNEUMONIA
10781 00-1 (duration) 1 yrs. 1 mos. 19 ds.

CONTRIBUTORY (SECONDARY) NONE KNOWN
 (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 SYMPTOMS
 (Signed) R. H. Chapman M. D.
 , 19 (Address) CHARLESTON-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 L. O. O. Cemetery DATE OF BURIAL 3/21 1930

20. UNDERTAKER Laird Co. Charleston Mo ADDRESS Charleston Mo

WRITE PLAINLY, 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.

