

JUN 24 1930

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

Do not use this space.

15202

1. PLACE OF DEATH

County ADAIR

Registration District No. 4

File No. 72

Township KIRKSVILLE MO

Primary Registration District No. 3001

Registered No. 72

City KIRKSVILLE MO (No.) St. Ward)

2. FULL NAME LETTA MAY MCKEIM

(a) Residence. No. 1014 WEST PATTERSON AVE Ward.

(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE
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 JESSIE MCKEIM
OCT 1909

6. DATE OF BIRTH (MONTH, DAY AND YEAR) OCT 21 1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
20 6 14

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

9. BIRTHPLACE (CITY OR TOWN) BEVIER MO
(STATE OR COUNTRY)

10. NAME OF FATHER OWIN TATE

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

12. MAIDEN NAME OF MOTHER BESSIE WILKINS

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

14. INFORMANT Linnis Mobis
(Address) KIRKSVILLE MO

15. FILED 5/9 30 C. A. Becker REGISTRAR
aliquity

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 5 1930

17. I HEREBY CERTIFY, That I attended deceased from apr 21 st 1930 to may 5 1930 that I last saw her alive on may 5 1930 and that death occurred on, the date stated above, at 4:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS

Peritonitis

14.5 A

12.9

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) Salpingitis (duration) yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF May 2. 30

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Robt. Stickler M. D.

, 19 (Address) Kirkville

*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 OAKWOOD CEMETERY
BEVIER MO DATE OF BURIAL 5-6-1930

20. UNDERTAKER Davis & Wilson ADDRESS Kirkville 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.

1930-5-5
1909-10-21

20-6-14

**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 Adair Registration District No. 4 File No. _____
 Township _____ Primary Registration District No. 3001 Registered No. 72
 City Kirkville St. _____ Ward _____

2. FULL NAME Letta May McKernan
 (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 (write the word) M

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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 5 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:
Peritonitis
 (yes Puerperal) (duration) yrs. mos. ds.
Salpingitis
 (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) _____, 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.

14. INFORMANT _____ (Address) _____

15. FILED July 8 1930 Mrs C H Beck REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

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

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