

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

Do not use this space.

19445

File No. 2439
Registered No. 2439
St. _____ Ward _____

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township 1st Primary Registration District No. 1002
City McKeon (No. 185-2 Benton)

2. FULL NAME

(a) Residence. No. 185-2 Benton 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 M 4. COLOR OR RACE M 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Mella May McKeon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 24 - 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
63 10 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter
(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) Ill.

10. NAME OF FATHER Jackson McKeon

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

12. MAIDEN NAME OF MOTHER Anna Samuels

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

14. INFORMANT Mrs. Mella McKeon
(Address) 185-2 Benton

15. FILED 11 19 30 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 19 30

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain Myocarditis
93c
91

CONTRIBUTORY (SECONDARY) Arterio-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? Yes
WHAT TEST CONFIRMED THE DIAGNOSIS?
(Signed) Stan Carbaugh
6/10 19 30 (Address) Carover

*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 Forest Hill DATE OF BURIAL June 12 1930
20. UNDERTAKER Rose & Henderson ADDRESS City

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.

