

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

Do not use this space.

25687

**1. PLACE OF DEATH**

County Verona  
Township Butte  
City Verona (No. 0)

Registration District No. 875  
Primary Registration District No. 3039

File No. 173  
Registered No. 173  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 1514 E. Austin St. 5 Ward \_\_\_\_\_

(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 10 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 W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 24 1878

7. AGE YEARS 58 MONTHS 10 DAYS 4 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Columbus Kansas

10. NAME OF FATHER Gordon Keithley

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

12. MAIDEN NAME OF MOTHER Maggie Grant

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

14. INFORMANT (Address) Mrs Claudia Keithley Nevada Mo

15. FILED 8/11/30 E. P. King REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/28 - 1930

17. I HEREBY CERTIFY, That I attended deceased from July 21 1930 to July 27 1930.  
That I last saw him alive on July 27 1930, and that death occurred, on the date stated above, at 11 A. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic arteriosclerosis, Generalized  
duration - several years  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Apoplexy or cerebral hemorrhage  
(duration) yrs. mos. ds. 4 ds.

18. WHERE WAS DISEASE CONTRACTED at place of death  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

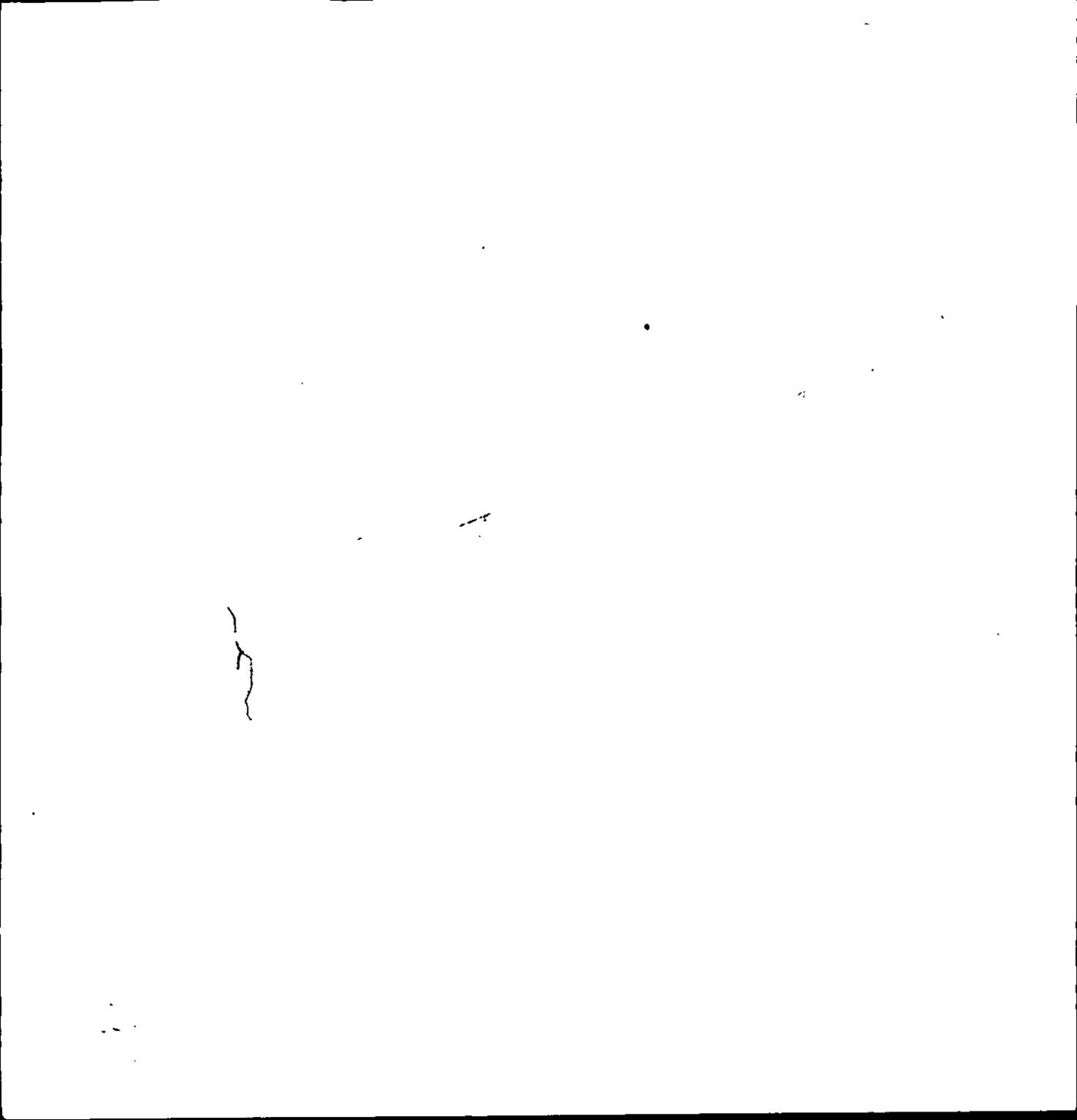
WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) A. G. Neal M. D.

7/21 1930 (Address) Nevada, 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.

PLACE OF BURIAL, CREMATION, OR REMOVAL Newton Cemetery DATE OF BURIAL 7/29 1930

20. UNDERTAKER Ferry Funeral Home Nevada ADDRESS \_\_\_\_\_



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Wernon Registration District No. 875- File No. ....  
 Township ..... Primary Registration District No. 3039 Registered No. ....  
 City Nevada (No. ....) St. .... Ward)

**2. FULL NAME**

William Keithly  
 (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 M 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) Sept 24-1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
59 10 4

**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) .....

14. INFORMANT (Address) .....

15. FILED 8/11/30 E. P. King REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 28 19 30

17. I HEREBY CERTIFY That I attended deceased from ..... to .....  
 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:

CONTRIBUTORY (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.

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

19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

5 A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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