

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

Do not use this space.

33130

1. PLACE OF DEATH Jackson
 County Jackson Registration District No. 309
 Township Jew Primary Registration District No. 677-115-667-2 File No. 4364
 City Mo (No. 677-115-667-2) Registered No. 4364 St. Mo Ward

2. FULL NAME Robert Edward Key
 (a) Residence. No. 2115 E 67th St of 15 Ward. (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 Wh 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) Oct 24 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin. 4

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

9. BIRTHPLACE (CITY OR TOWN) Kansas City
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Herbert Key

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

12. MAIDEN NAME OF MOTHER Edith Krebs

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

14. INFORMANT Herbert Key
 (Address) 2115 E 67th St

15. FILED 10/26 30 M.M. Brown
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 28 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1930, to Oct 28 1930, that I last saw him alive on Oct 26 35 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
Injury at birth
1000 (duration) yrs. mos. ds.
 CONTRIBUTORY Difficult labors
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 1000
 IS NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS Churcal
10/28 (Signed) Edwin M. D.
 (Address) 311 Argyle

*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 Oct 29 1930

20. UNDERTAKER Mrs. C. L. Forster ADDRESS K.C. 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.

Argyle Vi-1572 J
4937 Forest Hi-5986
We-4815