

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

Do not use this space.

36158

4564

**1. PLACE OF DEATH**

County Jackson  
Township Keosauqua  
City Keosauqua

Registration District No. 399  
Primary Registration District No. 1008

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

**2. FULL NAME**

(a) Residence. No. 611 E. 16<sup>th</sup> St. 3 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 Male 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 Susan McAuley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-6-1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
50 1 3

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Janitor  
(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) Ireland

10. NAME OF FATHER No Record

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) No Record

12. MAIDEN NAME OF MOTHER No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) No Record

14. INFORMANT Records Clerk  
(Address) Keosauqua Gen. Hosp

15. FILED 11/10, 1930 W. M. Crank REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-9-1930

17. I HEREBY CERTIFY, That I attended deceased from 11-9-1930 to 11-8-1930  
that I last saw him alive on 11-9-1930 and that death occurred, on the date stated above, at 8:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Streptococci meningitidis  
19A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 71A (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) J. J. Jewett M. D.

11-9, 1930 (Address) Keosauqua Gen. Hosp

\*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  
Mt. Washington Nov-12-1930

20. UNDERTAKER ADDRESS  
Mrs. C. L. Fritter 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.

