

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

Do not use this space.

1275

1. PLACE OF DEATH

County Jackson
Township Maize
City Keokuk

Registration District No. _____
Primary Registration District No. 441

File No. _____
Registered No. 105
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 441 West 15th St. St. 1 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 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 Cora Maunell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 18-1884

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
46 10 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machanicist
(b) General nature of industry, business, or establishment in which employed (or employer) Factory
(c) Name of employer 60

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

England

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 Cora Maunell
(Address) 441 West 15th St.

15.

FILED 1/9 31 M. M. Cronin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 9 1931

17. I HEREBY CERTIFY, That I attended deceased from Aug 22, 1930, to Jan 7, 1931, that I last saw her alive on 1-7-31, and that death occurred, on the date stated above, at 11:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asthma Bronchial

(duration) yrs. 6 mos. _____ ds. _____

CONTRIBUTORY (SECONDARY) Myocarditis, Chron.

(duration) yrs. 6 mos. _____ ds. _____

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical & Ray
(Signed) J. G. Potter, M. D.

1-8- 1930 (Address) 724 Prof. Bldg.

*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

Forest Hill 1-10 1931

20. UNDERTAKER

ADDRESS

Mrs. C. L. Foster 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS ESSENTIAL IN RECORD

Dr. Pallen
J. G.

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