

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

Do not use this space.

10008

**1. PLACE OF DEATH**

County Jackson

Registration District No. 399

File No. 1277

Township South

Primary Registration District No. 1002

Registered No. 1277

City Kansas City (No. 3228 Central)

St. Central

Ward)

**2. FULL NAME**

(a) Residence. No. 3228 Central St., 37 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)

single

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

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

March 26 - 1910

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, ..... hrs. or ..... min.

20

11

18

8. OCCUPATION OF DECEASED

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

Student

(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)

Kansas City, Mo.

10. NAME OF FATHER

Samuel J. Keating

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Pelham, Mo.

12. MAIDEN NAME OF MOTHER

Lillie Ponzelot

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

14. INFORMANT

(Address)

Samuel J. Keating  
3228 Central

15. FILED

3/16, 1931

M. M. Brown  
Asst REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

March 14 1931

17.

I HEREBY CERTIFY, That I attended deceased from

3-9 - 1931, to 3-14 - 1931

that I last saw him alive on 2-14-1931, and that death occurred, on the date stated above, at 4:15 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Lobar Pneumonia

108

(duration) ..... yrs. .... mos. 7 ds.

CONTRIBUTORY (SECONDARY)

(duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT A PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) P. H. Owens, M. D.

3-16, 1931 (Address) 1034 Ralls

\*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 St Mary Cem 3/17 1931

20. UNDERTAKER

ADDRESS

F. D. Russell Co 3256 Broadway

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.

