

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

Do not use this space.

34239

1. PLACE OF DEATH

County Harrison Registration District No. 346
Township Simpson Primary Registration District No. 5484
City Northfield No. _____ St. _____ Ward _____

File No. _____
Registered No. 4
St. _____ Ward _____

2. FULL NAME

Hamilton K. Keese

(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 50 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 Mary Elizabeth Keese

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 11, 1847

7. AGE YEARS MONTHS DAYS If LESS than a day, hrs. or min.
84 2 28

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

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Walter Keese
(Address) Northfield Mo.

15. FILED 10-21 1931 Chas. Adair
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Oct 8, 1931, to Oct 9, 1931, that I last saw him alive on Oct 6, 1931, and that death occurred, on the date stated above, at 5 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Liver
11 mos
16 (duration) yrs. 6 mos. 4 ds.

CONTRIBUTORY (SECONDARY) Smoking
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
Home
NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) J. H. Shipp, M. D.

Oct 9 - 1931 (Address) Grant City 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wearner Cemetery DATE OF BURIAL 10/10 1931

20. UNDERTAKER Arch C. Duffee ADDRESS Northfield

X. 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 PRINTING WITH UNFADING INK—THIS IS A PERMANENT RECORD

NOV 24 1931

