

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

Do not use this space.

20647

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Lees Primary Registration District No. 1002
 City Kansas City (No. 1120 Worton) St. _____ Ward _____

2. FULL NAME Anna Maria Keller
 (a) Residence, No. 1120 Worton St. _____ 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 Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 20-1933

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>1</u>	<u>2</u>	<u>5</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Infant
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Colonia, Ky

FATHER
 13. NAME Frank Keller
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER
 15. MAIDEN NAME Anna Masovic
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

17. INFORMANT Frank Keller
 (ADDRESS) 1120 Worton

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Colonia Ky DATE 4-28-35

19. UNDERTAKER Rehder
 (ADDRESS) Remo

20. FILED 6-27-34 M. M. Cronin Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 25, 1934

22. I HEREBY CERTIFY, That I attended deceased from March 1, 1934, to June 26, 1934
 I last saw her alive on June 25, 1934. Death is said to have occurred on the date stated above, at 9:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Pneumonia Bronchy
Inanition
 Date of onset 6-20

Other contributory causes of importance:
Inanition

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an-autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No Date of injury _____, 19____
 Where did injury occur? _____
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) M. H. Hines, D.O.
 (Address) 906 Paseo 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.

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

JUL 17 1934

