

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

Do not use this space.

43628

**1. PLACE OF DEATH**

County Macon  
Township Macon  
City Macon (No. ....)

Registration District No. 533  
Primary Registration District No. 3027

File No. ....  
Registered No. 121 St. .... Ward)

**2. FULL NAME** Kenneth Krouseup

(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 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 single (Write the word)  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 4 - 1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
0 1 29

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.  
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) Macon Mo

13. NAME Raymond Krouseup

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Beverly Mo

15. MAIDEN NAME Gene Burkhardt

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Mo

17. INFORMANT (ADDRESS) Raymond Krouseup Macon Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Wortham Cemetery DATE 12-5 1934

19. UNDERTAKER (ADDRESS) W. E. Edwards Beverly Mo

20. FILED Dec 10 1934 Kaic Cross Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 2nd 1934

22. I HEREBY CERTIFY That I attended deceased from

..... 19..... to Dec 3rd 1934

I last saw h. live on Dec 3rd 1934 Death is said

to have occurred on the date stated above, at 9 P m.

The principal cause of death and related causes of importance were as follows:

Bronchial Pneumonia Date of onset

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Other contributory causes of importance:

Tender age of the infant

Name of operation None Date of

What test confirmed diagnosis? Chest X-ray 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? None

(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.....

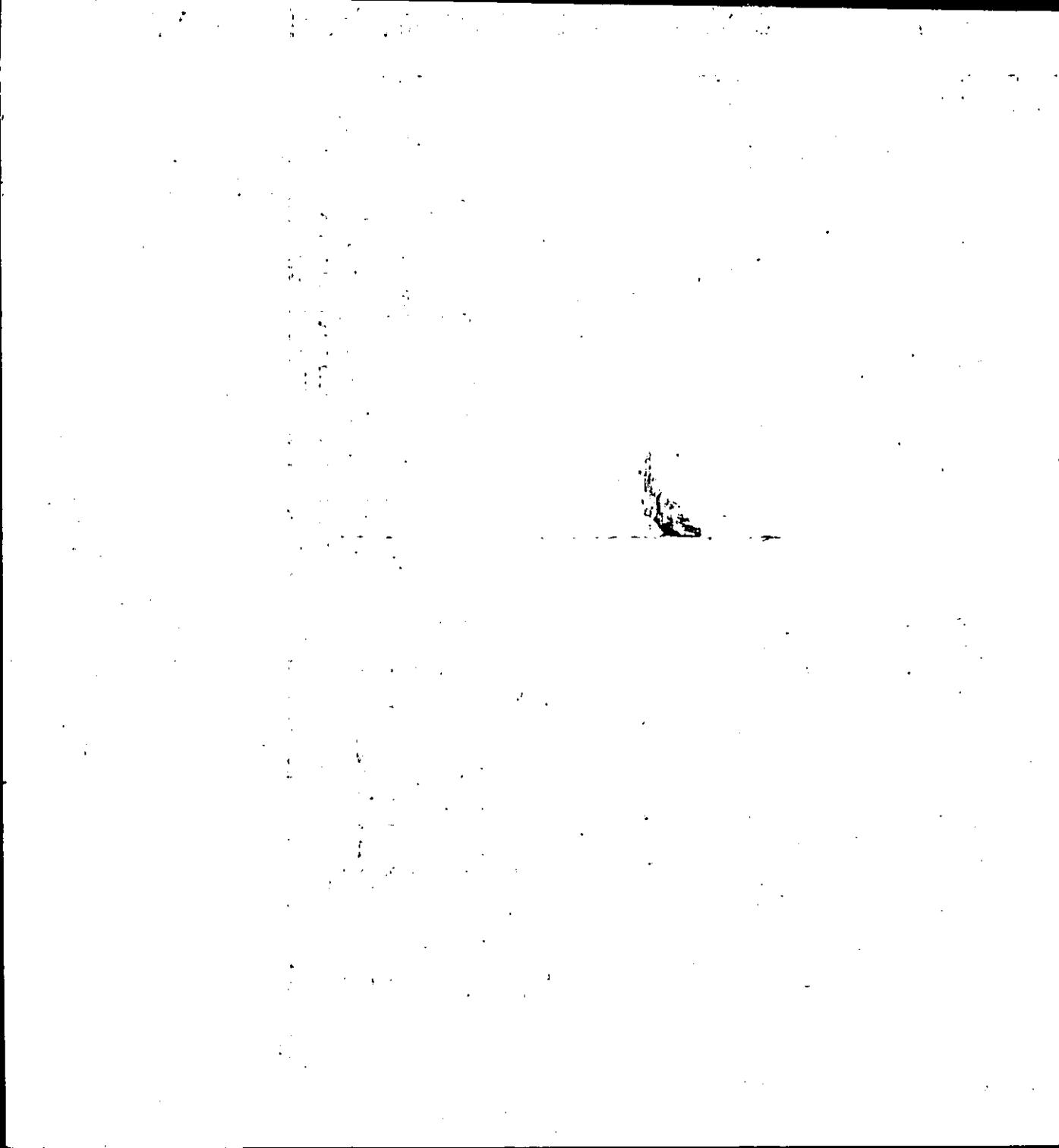
24. Was disease or injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) Minnie L. Pennick, M.D.

(Address) Macon 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.



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Macon

Registration District No. 533

Township .....

Primary Registration District No. 3027

City .....

(No. .... St. .... Ward)

File No. ....

Registered No. 121

**2. FULL NAME**

Kenneth Courcy

(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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED s (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 9, 1934

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

22. I HEREBY CERTIFY, That I attended deceased from

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

....., 19....., to....., 19.....

7. AGE YEARS MONTHS DAYS If LESS than day, or

..... at saw n..... alive on....., 19..... Death is said

to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Bronchial pneumonia Date of onset

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) .....

Other contributory causes of importance:

None

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

13. NAME

Name of operation..... Date of.....

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

What test confirmed diagnosis?..... Was there an autopsy?.....

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... 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.

17. INFORMANT (ADDRESS)

Manner of injury.....

Nature of injury.....

18. BURIAL, CREMATION, OR REMOVAL

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

19. UNDERTAKER (ADDRESS)

20. FILED Dec 10, 1934 Kene Cross Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Exact statement of OCCUPATION is very important. Do not leave blank. Do not use property classmate.

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