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

1 PLACE OF DEATH

County Linn

Township Parson Creek Registration District No. 503 File No. 31129

or

Village Fountain Grove Primary Registration District No. 5664 Registered No. 182

or

City ..... (NO. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Alice Keith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) widow

6 DATE OF BIRTH March 27th (Month) (Day) 1861 (Year)

7 AGE 76 yrs. 5 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmers - Retired
(b) General nature of industry business, or establishment in which employed (or employer) Housekeeper

9 BIRTHPLACE (City or town, State or foreign country) Galliapoose Ohio

PARENTS

10 NAME OF FATHER Thomas Deem

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) England

12 MAIDEN NAME OF MOTHER Julia James

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. R. Keith

(Address) Fountain Grove Mo

15

Filed 8-31, 1937 E. H. Weir Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 30 (Day), 1937 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 24, 1937, Aug 30, 1937, that I last saw her alive on Aug 29, 1937, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia following Hip fracture on Aug 20 1937

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intra Capsular Hip fracture Age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Hardy M. D.

Aug 30, 1937 (Address) Sumner Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Meadville Mo

DATE OF BURIAL Sept 1, 1937

20 UNDERTAKER Smiley Funeral Home

ADDRESS Whiteling Mo

194B

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....

that I last saw h.....alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

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

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ....., 191.....

20 UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

31129

Do not use this space.

1. PLACE OF DEATH
(a) County: Linn — Registration District No.: 503
(b) Township: Parson Creek — Primary Registration District No.: 3669 — Registered No.:
(c) City: (d) Street No.: St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME: Mary Alice Keith
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Wid

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

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

7. AGE: Years 76 — Months 5 — Days 3 — If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

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

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Aug 31, 1937 E. E. Weir Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 30, 1937

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19
I last saw h 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:

	Date of onset
Hypostatic Pneumonia	
following hip fracture	

Other contributory causes of importance:

Name of operation: None — Date of
What test confirmed diagnosis? Clinical — Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accid — Date of injury Aug 30, 1937
Where did injury occur? Duncan Grove Mo
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Home
Manner of injury Fell
Nature of injury Fractured hip

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) F. W. Hardy, M. D.
(Address) Jasper Mo

SUPPLEMENTARY

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.