

FILED FEB 7 1940

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

3031
Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 547

(b) Township Marion Primary Registration District No. 3029 Registered No. 2

(c) City Hannibal (d) Street No. Levee Hospital 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. 7 (f) How long in U. S., if of foreign birth? yrs. mos. ds. _____

2. PRINT FULL NAME AMERICUS Z. KEITH

(a) Residence, No. GURRYVILLE, MO. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 18 - 1857

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
82	9	9	12	Retired

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

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) Hannibal Mo. Marion County

FATHER

13. NAME JAMES KEITH

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion County, Mo.

MOTHER

15. MAIDEN NAME SARAH LEFEVER

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion County, Mo.

17. INFORMANT (ADDRESS) Mr. John Lawson

18. BURIAL, CREMATION, OR REMOVAL PLACE New Lebanon Mo. DATE Jan 1 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gold & Son Hannibal Mo.

20. FILED Jan 2 1940 W. B. Fisher Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 30 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 23 1939, to Dec 30 1939. I last saw him alive on Dec 30 1939. Death is said to have occurred on the date stated above, at 5 P.M.

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

Terminal Hypostatic Pneumonia
Leukemia - W.P.N. 190 mgm/lc
Cardio Nephrotic
Uremia 5 mgm/lc

Other contributory causes of importance: General Debility
Cerebral Arterio Sclerosis

Name of operation None Date of operation _____
What test confirmed diagnosis? Cerebral Laboratory NO Was there an autopsy? _____

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. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) E. D. Bullman M. D.
488 (Address) Hannibal 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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

Jane Fields Nepton

Licensed Embalmer No. 4093

P. O. Address Franklin, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.