

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**

Do not use this space.

12623

MAY 27 1935

1. PLACE OF DEATH

County Henry Registration District No. 347
 Township Clinton Primary Registration District No. 3018
 City Clinton Mo. (No. _____) St. _____ Ward _____

File No. 72
 Registered No. _____

2. FULL NAME

Albert Keifer
 (a) Residence, No. 528 S - Orchard 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 <u>M</u>	4. COLOR, OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. <u>MARRIED, WIDOWED, OR DIVORCED</u> HUSBAND OF (OR) WIFE OF <u>Belle Keifer</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 12 - 1851</u>		
7. AGE	YEARS <u>83</u>	MONTHS <u>7</u>
		DAYS <u>14</u>
		If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Railway Employee</u>	
	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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-26, 1935
 22. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1935, to April 26, 1935.
 I last saw him alive on April 26, 1935. Death is said to have occurred on the date stated above, at 10.30 a.m.
 The principal cause of death and related causes of importance were as follows:

Chronic myocarditis
 Arterio-sclerosis
 senility
 Date of onset 11-25

Other contributory causes of importance:
Arterio-sclerosis & senility

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? _____ 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) Albert Keifer, M. D.
 (Address) Clinton Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mt Vernon Ohio</u>
MOTHER
13. NAME <u>Don't know</u>
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>
15. MAIDEN NAME <u>Don't know</u>
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>
17. INFORMANT (ADDRESS) <u>Mrs Jesse Keifer</u>
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Englewood</u> DATE <u>4/28</u> 19 <u>35</u>
19. UNDERTAKER (ADDRESS) <u>Spore & Son</u>
20. FILED <u>6</u> 19 <u>35</u> <u>J. W. Hampton</u> Registrar.

