

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

Do not use this space.

21340

1. PLACE OF DEATH

County *Madaway*
Township *Green*
City *Quintman* (No.)

Registration District No. *698*

Primary Registration District No. *5830*

File No. *2*

Registered No.

St. Ward)

2. FULL NAME

(a) Residence, No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. *6* 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 (*write the word*) *single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec 27 1933*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
		<i>5</i>	<i>5</i>	

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

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

10. Date deceased last worked at this occupation (month and year) *L* 11. Total time (years) spent in this occupation *L*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Quintman Mo*

13. NAME *Orla E Keever*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Atchison Mo*

15. MAIDEN NAME *Hazel Master*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Madaway Mo*

17. INFORMANT (ADDRESS) *Carl Keever*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Manlyville Mo June 2, 1934*

19. UNDERTAKER (ADDRESS) *none*

20. FILED *7/10* 19 *4* *J. E. Jones* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June 1 1934*

22. I HEREBY CERTIFY, that I attended deceased from *May 30 1934* to *June 1 1934*
I last saw him alive on *May 30 1934* Death is said to have occurred on the date stated above, at *10 P. M.*

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

Gastro Enteritis Date of onset

1196 / 1934

Other contributory causes of importance: *L*

Name of operation *L* Date of *L*

What test confirmed diagnosis? *L* Was there an autopsy? *L*

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

Accident, suicide, or homicide? *L* Date of injury *U*, 19 *34*

Where did injury occur? *L* (Specify city or town, county, and State) *U*

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) *J. E. Gannon*, M. D.

(Address) *Skidmore 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.

JUN 25 1934

WRITE PERMIT WITH STATE BOARD OF HEALTH

