

EAR 27

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

Do not use this space.

2592

1. PLACE OF DEATH
County Ray Registration District No. 914
Township Grape Grove Primary Registration District No. 6235
City (No.) St. Ward)

2. FULL NAME Anna Keel
(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 <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>widowed</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April-2-1839</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>91</u>	<u>9</u>	<u>23</u>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>At home</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>with son</u> (c) Name of employer				
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky Ky 2</u>				
PARENTS	10. NAME OF FATHER <u>J. T. Limesy</u>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>			
	12. MAIDEN NAME OF MOTHER <u>Harriet Heald</u>			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>			
14. INFORMANT <u>Will Keel</u> (Address) <u>Richmond Mo.</u>				
15. FILED <u>Feb 11, 1931</u> <u>W. E. Gant</u> REGISTRAR				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan-23-1931

17. I HEREBY CERTIFY, That I attended deceased from April 24, 1930, to Jan 24, 1931, and that that I last saw her alive on Jan 22, 1931, and that death occurred, on the date stated above, at 2 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis (Hemiplegia)
500
11B

(duration) yrs. 9 mos. ds.

CONTRIBUTORY Flu (SECONDARY) (duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED At home
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF ...

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Marvin Formis M. D.
Jan 26, 1931 (Address) Hardin, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Hickory Grove Cem</u>	DATE OF BURIAL <u>Jan 26 1931</u>
20. UNDERTAKER <u>Jno W. Knipschild</u>	ADDRESS <u>Hardin Mo.</u>

Every year 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.

