

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

20168

1. PLACE OF DEATH

County Ray
Township Richmond
City Richmond No. _____ St. _____ Ward _____

Registration District No. 744
Primary Registration District No. 3025

File No. _____
Registered No. 919 (919)

2. FULL NAME

Henry Clay Keel

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

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. (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) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-1-1838

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
86 11 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Kentucky

10. NAME OF FATHER William Keel

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Ann Keel

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Kentucky

14. INFORMANT Wile Keel (Address) Richmond Mo

15. FILED May 17, 1920 R. L. Hamilton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-17-1920

17. I HEREBY CERTIFY, That I attended deceased from May 17 1920, to May 17 1920, that I last saw h. alive on May 17 1920, and that death occurred, on the date stated above, at 3:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) 64 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____
DID AN OPERATION PRECEDE DEATH, _____ DATE OF _____

WAS THERE AN AUTOPSY, _____
WHAT TEST CONFIRMED DIAGNOSIS, _____
(Signed) A. R. Penning, M. D.
5-19, 1920 (Address) Richmond 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wall B & Ray Co Mo DATE OF BURIAL 5-19 1920
ADDRESS _____
20. UNDERTAKER Richmond Mo

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

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

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.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.....) St..... Ward.....

2. FULL NAME

(a) Residence, No....., Ward.....
 (Usual place of abode)
 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.
 (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX.....
 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) HUSBAND OF WIFE OF.....

6. DATE OF BIRTH (MONTH, DAY AND YEAR)
 7. AGE YEARS MONTHS DAYS
 IF LESS than 1 day, hrs. or min.

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

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

10. NAME OF FATHER.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER.....

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT (Address).....

15. FILED....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., and that (that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....
 THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (disease)..... yrs. mos. ds.
 WHERE WAS DISEASE CONTRACTED..... (disease)..... yrs. mos. ds.
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS....., M. D.

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... DATE OF BURIAL.....

20. UNDERTAKER..... ADDRESS.....