

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

Do not use this space.

1. PLACE OF DEATH

County Carter
Township Kelley
City (No. _____) _____ St. _____ Ward _____

Registration District No. 143
Primary Registration District No. 5205

File No. 7506
Registered No. _____

2. FULL NAME

Margaret Jane Kennedy
(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 13, 1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	72	5	5	

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

9. BIRTHPLACE (CITY OR TOWN) Lincoln Co. Tenn.
(STATE OR COUNTRY) _____

10. NAME OF FATHER Philip McBay

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

12. MAIDEN NAME OF MOTHER H.A. Walker

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

14. INFORMANT Marthy D. VanBuren, mo.
(Address) _____

15. FILED 3/18/27 I. W. Cotton
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) March 18 1927

17. I HEREBY CERTIFY That I attended deceased from Jan 9, 1927 to March 18, 1927 that I last saw her alive on March 14, 1927, and that death occurred, on the date stated above, at 2:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Neuritis following gastritis
Influenza 1927
(duration) yrs. mos. da. 3 7 1

CONTRIBUTORY (SECONDARY) Gastritis 3 or 4 weeks
not well since June 1926
(duration) yrs. mos. da. _____

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DIED IN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) I. W. Cotton, M. D.
3/18, 1927 (Address) Van Buren, 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 Eastwood DATE OF BURIAL 3/19 1927

20. UNDERTAKER Wm. Samples ADDRESS Van Buren

26 1927

MAINT RECORD

WRITE P

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