

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

Do not use this space.

8043

**1. PLACE OF DEATH**

County Lickson (Registration District No. 30) File No. 891  
 Township Scott (Primary Registration District No. 30) Registered No. 891  
 City Kansas City, Mo. (St. Laborer's Hospital Ward)

**2. FULL NAME**

Mollie Irene Kennell  
 (a) Residence No. 3429 Olive 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 27 1907

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
20 3 10

**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) Burlington (STATE OR COUNTRY) Iowa

PARENTS

10. NAME OF FATHER J. Albertson

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

12. MAIDEN NAME OF MOTHER Minnie Carter

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

14. INFORMANT W. K. Kennell (Address) 3429 Olive

15. FILED 3/27 1927 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/7 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to March 4, 1927 that I last saw h. alive on March 4, 1927 and that death occurred, on the date stated above, at 12:13 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

66F  
12:13 60W  
Thyrotosis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.  
 CONTRIBUTORY Chrom. appendic (Operated)  
 (SECONDARY) (duration) 8 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? yes DATE OF Feb 26/27

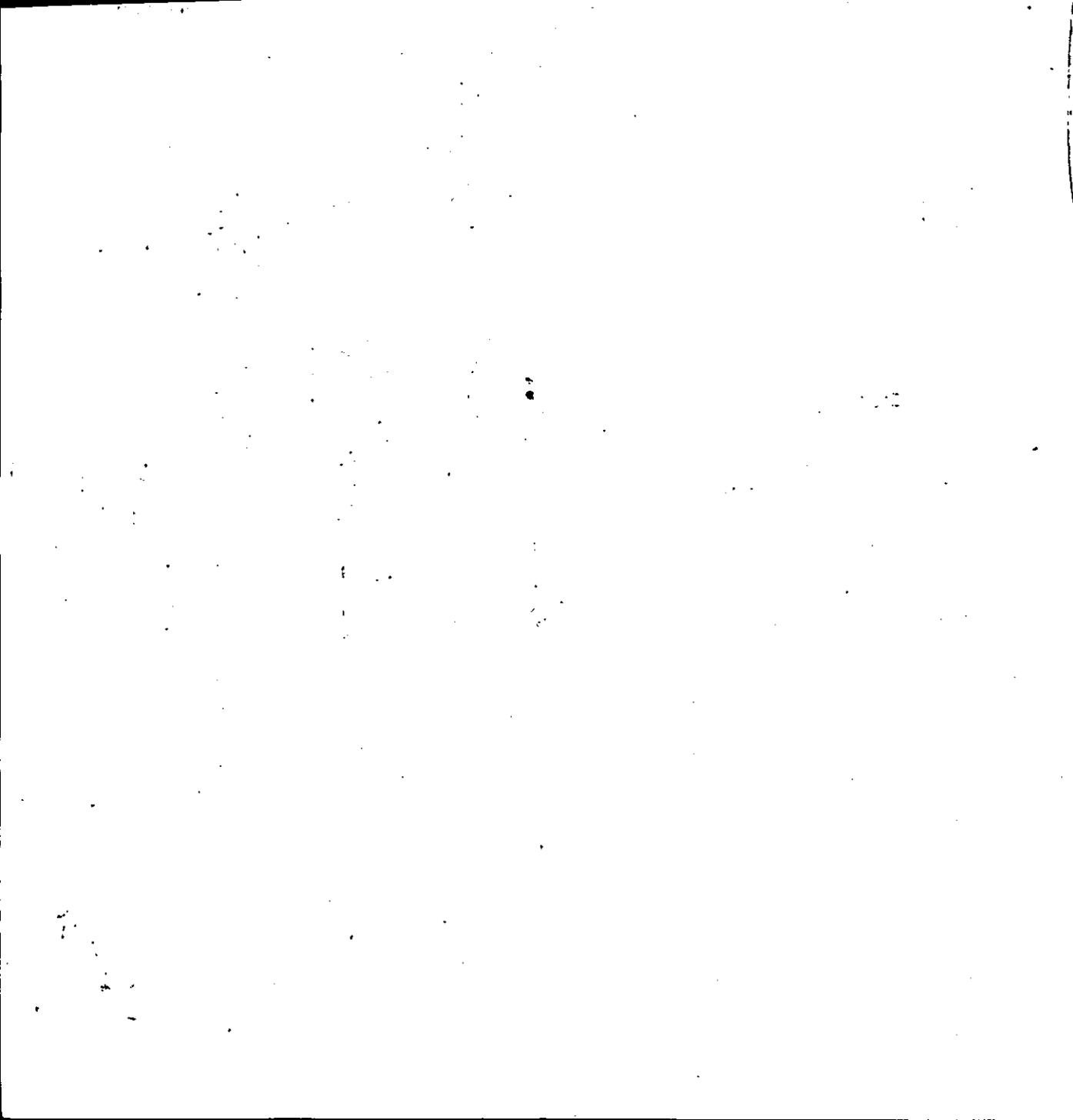
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Chronic symptoms  
 (Signed) Wm. J. Quay, M. D.

(Address) 810 Chambers Bldg

\*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 Keokuk Kansas DATE OF BURIAL 3/7 1927  
 20. UNDERTAKER W. Mast ADDRESS 1915 East 45



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County Jackson Registration District No. 399 File No. \_\_\_\_\_  
 Township Sawyer Primary Registration District No. 1002 Registered No. 897  
 City Man. City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Mollie June Kennell  
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 22, 1904

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>12</u>	<u>2</u>	<u>3</u>	<u>10</u>	

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 2 1927

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

\_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
 (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 3/2 27 M.M. Brown REGISTAR

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) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address) \_\_\_\_\_

\*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 \_\_\_\_\_ 19\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-8043