

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

Do not use this space.

8189

1. PLACE OF DEATH

County *Jackson*
Towship *Kear*
City *Kansas City*

Registration District No. *398*
Primary Registration District No. *1002*
(No. *Trinity Lutheran Hos.*)

File No. _____
Registered No. *1042*
St. _____ Ward _____

2. FULL NAME

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

Cedar Kans.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *14* da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Fr* 4. COLOR OR RACE *Wh* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 18-1895*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
31 10 21

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) (STATE OR COUNTRY) *Kansas*

10. NAME OF FATHER *Wm. Fetocco*

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

12. MAIDEN NAME OF MOTHER *Melba Hobbs*

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

14. INFORMANT (Address) *Frank Kelling Cedar Ks.*

15. FILED *Mar. 11, 27 M. M. Crome* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-11-1927*

17. I HEREBY CERTIFY, That I attended deceased from *3-7*, 1927, to *3-11*, 1927 (that I last saw her alive on *3-11*, 1927, and that death occurred, on the date stated above, at *3:15 am.*)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis (Chronic)
139B
93? (duration) ? yrs. mos. da.

CONTRIBUTORY (SECONDARY) *Operation (3-8-27)*
Removal of both tubs, Proxary - suppurative uterus (duration) ? yrs. mos. da.
Cervical perineal repair

18. WHERE WAS DISEASE CONTRACTED *Cedar Kans*
IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *3-8-27*

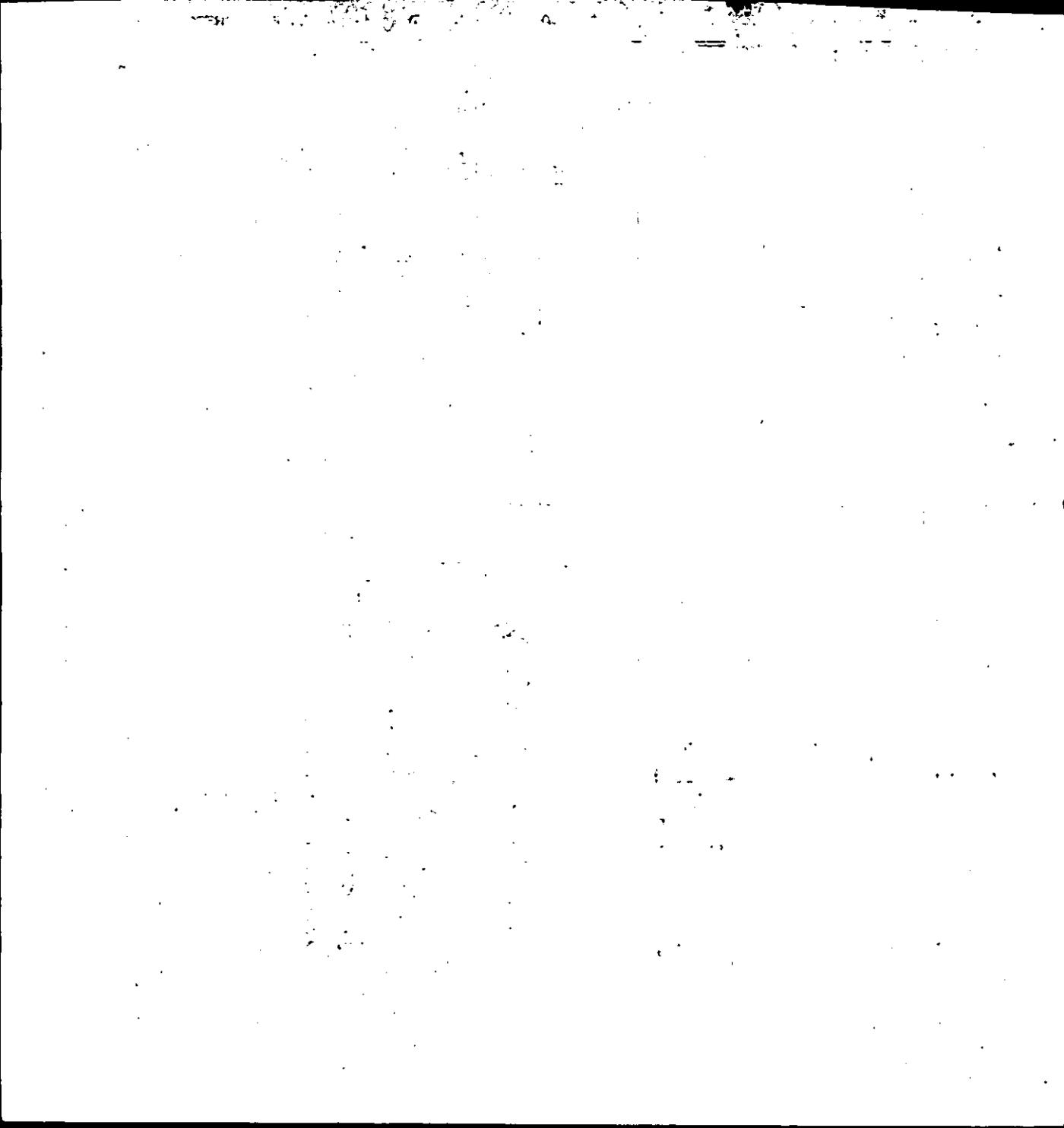
20. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
31 (Signed) *Geo. B. Honberg* M. D.
911, 1927 (Address) *410 Rialto 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 *Cedar, Kans.* DATE OF BURIAL *3-11 1927*

20. UNDERTAKER *P. O. Ludray & Sons* ADDRESS *City*



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township W. City
City W. City (No.)

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 1042
St. Ward

2. FULL NAME

Edna Kelling

(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)

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 Mar 11 1927 M. M. Corbett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 11 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mumps (Chronic)
Stomatitis (bilateral) cystic
degeneration of ovary - not malignant
OPERATION

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) W. H. Norberg, 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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

RECORDED BY LAW

PARENTS

5-28-5