JUL 29 1927

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

Do not use this space.

20461

1. PLACE OF DEATH
County Vernon
Township ~~Center~~
City Nevada (No. ..... St. ..... Ward)
Registration District No. 875
Primary Registration District No. 3039
File No. .....
Registered No. 119

2. FULL NAME Missouria Ann Kelley
(a) Residence. No. 1117 E Austin St., 5 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: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Wife of S. J. Kelley

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: S J Kelley

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 28 1852

7. AGE: 75 YEARS, 3 MONTHS, 12 DAYS. If LESS than 1 day, ... hrs. or ..... min.

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: Sam Home

9. BIRTHPLACE (CITY OR TOWN): B. K.
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: Zeblin Lewis
11. BIRTHPLACE OF FATHER (CITY OR TOWN): B. K.
(STATE OR COUNTRY): Missouri
12. MAIDEN NAME OF MOTHER: Mary Kahn
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): B. K.
(STATE OR COUNTRY): Maryland

14. INFORMANT: S. J. Kelley
(Address): Nevada Mo

15. FILED 7/6 1927 E. R. Kinsey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 13 1927

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1927, to June 13, 1927 that I last saw her alive on June 13, 1927, and that death occurred, on the date stated above, at 8.45 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia
(duration) ..... yrs. ..... mos. + ds.

CONTRIBUTORY (SECONDARY): Bronchial Asthma about (duration) 10 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 0/0001
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? symptoms
(Signed) H. W. Lancaster, M. D.
6-10-1927 (Address) Nevada 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: Click Cemetary
DATE OF BURIAL: 6/22 1927

20. UNDERTAKER: Ferry Bros Nevada Mo
ADDRESS

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.