

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

Do not use this space.

32506

1. PLACE OF DEATH

County Sullivan
 Township West
 City Milan (No. _____) St. _____ Ward _____

Registration District No. 852
 Primary Registration District No. 4518

File No. _____
 Registered No. 76

2. FULL NAME

Benjamin Kelsall

(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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 27/1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
8 26

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) Milan (STATE OR COUNTRY) Mo.

10. NAME OF FATHER William N Kelsall

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

12. MAIDEN NAME OF MOTHER May Webb

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

14. INFORMANT Wm N Kelsall (Address) Milan Mo

15. FILED 9-26, 1928 Bertha McClard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 23 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 22, 1928, to Sept 23, 1928 that I last saw him alive on Sept 23, 1928, and that death occurred, on the date stated above, at 10 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho-Pneumonia

1074 (duration) _____ yrs. _____ mos. 4 da.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. _____

19. DID AN OPERATION PRECEDE DEATH. _____ DATE OF _____

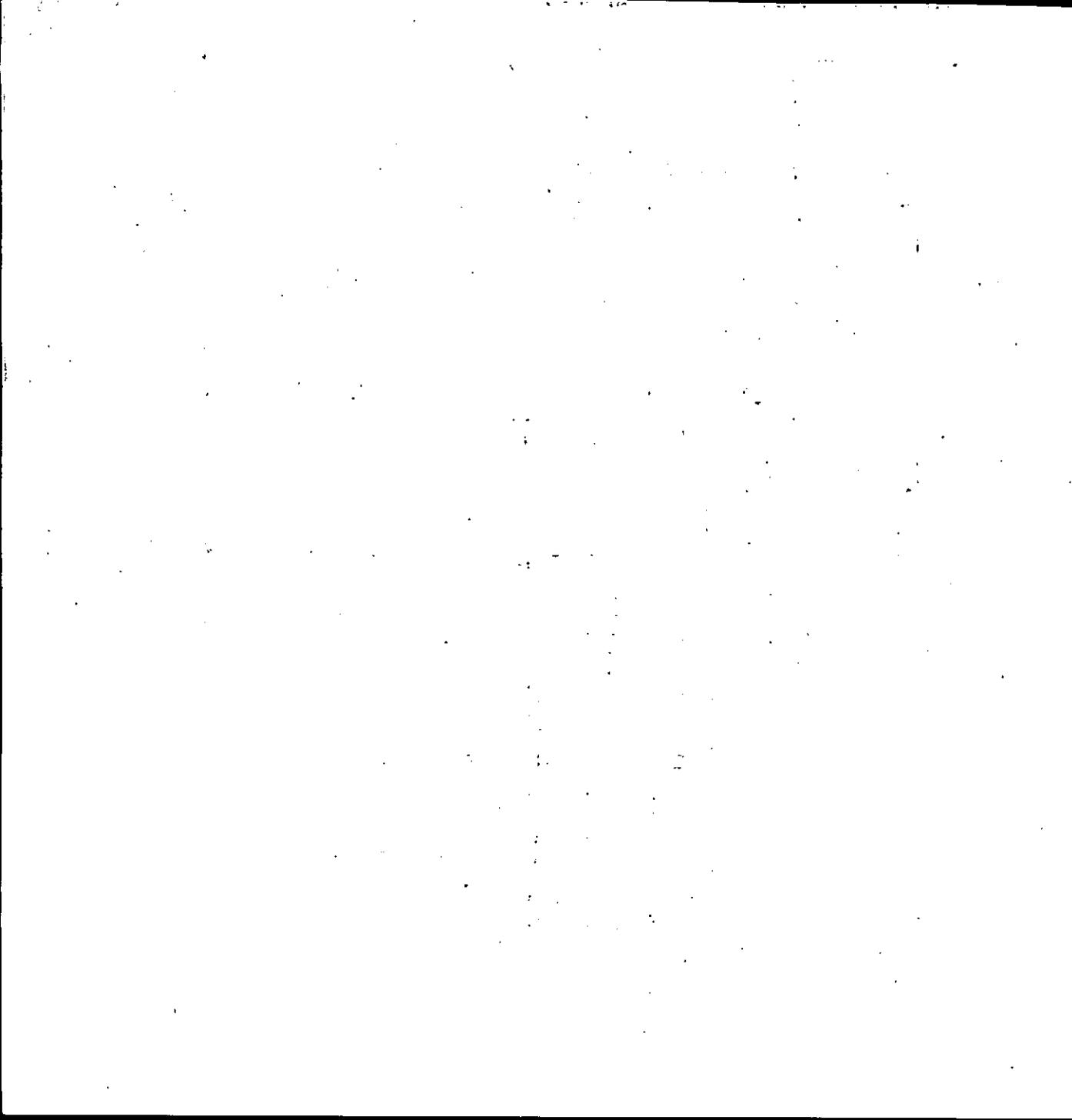
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS. (Signed) R. J. Garner, M. D. 9/24, 1928 (Address) Milan, 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 Oak Grove Cem DATE OF BURIAL Sept 25 1928

20. UNDERTAKER C. J. Schaefer ADDRESS Milan Mo



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Sullivan Registration District No. 852 File No.
Township Primary Registration District No. 4518 Registered No. 46
City Millers (No.) St. Ward)

2. FULL NAME Benjamin Kelsell
(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 27 - 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
8 76

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 9/26, 28 Bartha McClary REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 23 19 28

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho - pneumonia
Primary Cause
(duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRAICTED 1000
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.

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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

S-32506