

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

Do not use this space.

37125

**1. PLACE OF DEATH**

County Lickson  
Towship Kaw  
City Kansas City (No. 1072)

Registration District No. 399  
Primary Registration District No. 1072

File No. 4776  
Registered No. 4776  
St. Old City Hospital Ward

**2. FULL NAME**

Lewis Kelly  
(a) Residence No. 2609 E 53rd St

St. 16 Ward.  
(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 Male 4. COLOR OR RACE Col. 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) Unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
55

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Drayman  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ark.  
(STATE OR COUNTRY)

10. NAME OF FATHER Lewis Kelly

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

12. MAIDEN NAME OF MOTHER Dont No

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dont No  
(STATE OR COUNTRY)

14. INFORMANT Angela Kelly  
(Address) 2609 E 53rd St

15. FILED 11/27 28 M. M. Corwin  
Assr REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-26-28

17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner, 1928, at Old City Hospital, and that death occurred, on the date stated above, at 30 m.

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

Acute Peritonitis

CONTRIBUTORY (SECONDARY) Process of Rt. Kidney (duration) 24 hrs. ds.  
(ruptured) (duration) 1 yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? DATE OF

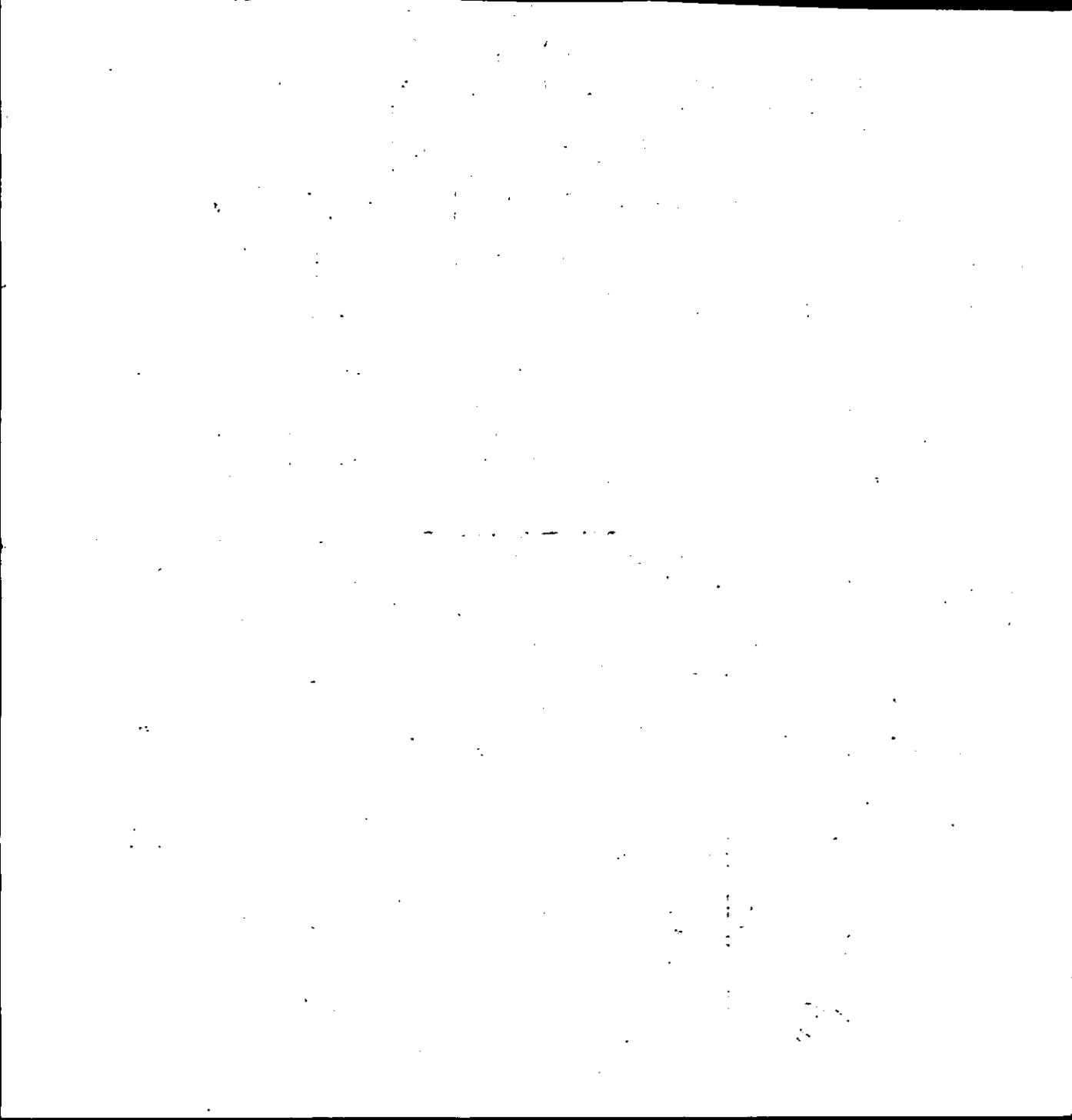
WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? no autopsy  
(Signed) no, M. D.  
11/26, 1928 (Address) Deputy Coroner

\*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 Highland Cemetery DATE OF BURIAL 11/28 1928

20. UNDERTAKER West Appleton Jones ADDRESS 1600 E 19th



**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..... Registration District No. 399 File No. ....  
 Township..... Primary Registration District No. 1002 Registered No. 4776  
 City R. City (No. ....) St. .... Ward)

**2. FULL NAME**

(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.

*Lewis Kelley*

**PERSONAL AND STATISTICAL PARTICULARS**

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

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 1/27, 28 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-26-1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

*Acute peritonitis*  
*telemalgia*

CONTRIBUTORY (SECONDARY) *abscess of rt. kidney*  
*(ruptured)* (duration) yrs. mos. ds.

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

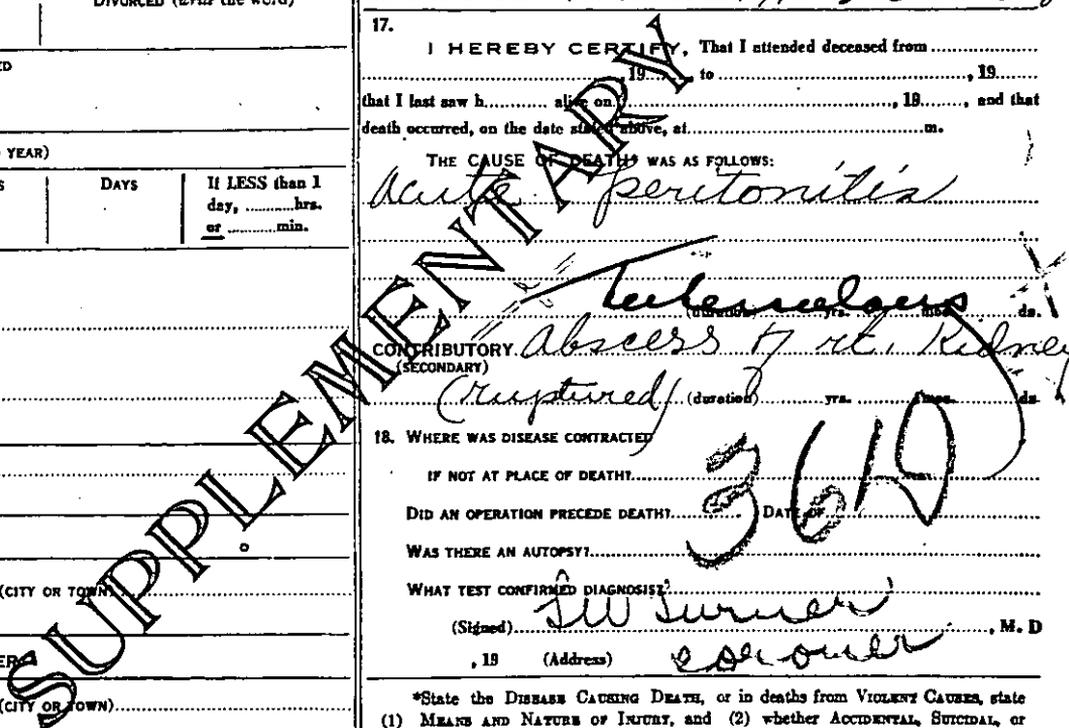
DID AN OPERATION PRECEDE DEATH? 3619 DATE OF .....

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) SW Sumner, M. D.  
 , 19 (Address) Essex

\*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



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

S-37125