JAN 24 1960

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

41473

1 PLACE OF DEATH
County: Laclede
Township or Village: Sleepfir
City: (No. ..... St. ..... Ward)
Registration District No. 450 File No. 14
Primary Registration District No. 5615 Registered No. 14
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME: May Belle Kennell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: W
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married
6 DATE OF BIRTH: Oct (Month) 8 (Day) 1878 (Year)
7 AGE: 50 yrs. 2 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.?
8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeping
(b) General nature of industry business, or establishment in which employed (or employer):
9 BIRTHPLACE (City or town, State or foreign country): Laclede Co Mo.

PARENTS
10 NAME OF FATHER: S H Alexander
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo.
12 MAIDEN NAME OF MOTHER: Mary Rebecca Dasser
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Hora Cole
(Address) Eldridge

15 Filed Dec 28, 1928 H A Atkins Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 24 (Day), 1928 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept. 1, 1928, to Dec 24, 1928, that I last saw her alive on Dec. 21, 1928, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:
Cancer, Breast and shoulder right side
50
53 1/7 (Duration) one yrs. 4 mos. 17 ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. T. Casey M. D.
Dec 2 3, 1928 (Address) Adamson Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Lebanon Mo
DATE OF BURIAL: Dec 26, 1928
20 UNDERTAKER: Palmer
ADDRESS: Lebanon

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191..... (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h.....alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.