

N. R.—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.

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

Do not use this space.

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1. PLACE OF DEATHCounty JacksonRegistration District No. 399Township KawPrimary Registration District No. 1002City Kansas City No. St. Joseph's HospitalFile No. 132Registered No. 132

St. _____ Ward _____

2. FULL NAME John T Kelly(a) Residence. No. Leavenworth St. Kans

(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)**Divorced

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Mrs. Harriet Kelly**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Aug 7, 1857**7. AGE**

YEARS

MONTHS

DAYS

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

725unk**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

Mercantile Merchant

(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)

Connecticut**10. NAME OF FATHER**Not Known**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Ireland**12. MAIDEN NAME OF MOTHER** Not Known**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Not Known**14.**INFORMANT Mrs. Doris Keabhart
(Address) Leavenworth, Kans**15.**FROSE Jan 11, 29 M. M. Cronin
REGISTRAR Assn**MEDICAL CERTIFICATE OF DEATH****16. DATE OF DEATH (MONTH, DAY AND YEAR)** Jan 9 19 2917. I HEREBY CERTIFY, That I attended deceased from Jan 9 19 29 to Jan 9 19 29 that I last saw him alive on Jan 9 19 29 and that death occurred, on the date stated above, at 9 A m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pneumonia

CONTRIBUTORY (SECONDARY)

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) M. L. St. Clair, M. D.1/11, 1929 (Address) 5242 St. John

*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**M. M. Cronin Jan 11, 29**20. UNDERTAKER****ADDRESS**Quirk & Tobin Co--20 W Linwood

W. L. M. Jones

5242 St. John Bevil

100 St. John

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