

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

Do not use this space.

2416

1929
62
1
4

1. PLACE OF DEATH
 County Madison Registration District No. 038
 Township St. Michael Primary Registration District No. 0974
 City Fredericktown No. _____ St. _____ Ward _____

2. FULL NAME Benjamin T. Kelley
 (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 Male **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 7 - 1853

7. AGE
 YEARS 75 MONTHS 10 DAYS 5
 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer 1917-1952
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Madison Co. Mo.
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Reuben Kelley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Madison Co. Mo.

12. MAIDEN NAME OF MOTHER Lydia Berry

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

14. INFORMANT Perry Hawn
 (Address) Fredericktown Mo.

15. FILED 1-21-24 C. U. Wiers
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 12 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1929, to Jan 16 1929, that I last saw him alive on Jan 12 1929, and that death occurred, on the date stated above, at 12:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Plum ammonia fruit
canine fruit
 (duration) yrs. mos. ds. _____

CONTRIBUTORY (SECONDARY) aspiration pneumonia
 (duration) yrs. mos. ds. _____

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

DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

19. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) C. U. Wiers M. D.
 , 19 (Address) Fredericktown 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 Family Cemetery Madison Co. **DATE OF BURIAL** Jan. 14 1929

20. UNDERTAKER Ed. H. Webb Fredericktown Mo.

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.

