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

Do not use this space.

7896

1. PLACE OF DEATH
County St. Louis — Registration District No. 1123 — File No.
Township Carondelet — Primary Registration District No. 6248 B — Registered No. 59
City Jefferson Barracks, Mo. U.S. Veterans' Hospital, Jefferson Brks. Mo. Ward)

2. FULL NAME Fred J. Kelsey. — I. R. Wagner, M.D. Medical Officer In Charge.
(a) Residence. No. 5019 Frankfort Ave., St. Louis County, Mo. (Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred un yrs. 1m mos. own 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): Divorced.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 7, 1894

7. AGE: Years 34 | Months 2 | Days 24 | If LESS than 1 day, ...hrs. or ....min.

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

9. BIRTHPLACE (CITY OR TOWN) Unavailable.
(STATE OR COUNTRY) Missouri.

PARENTS

10. NAME OF FATHER Unavailable.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unavailable.
(STATE OR COUNTRY) Unavailable.
12. MAIDEN NAME OF MOTHER Unavailable.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unavailable.
(STATE OR COUNTRY) Unavailable.

14. INFORMANT J. E. Wheeler, Medical Officer.
(Address) U.S. Veterans' Hospital, Jefferson Barracks Mo.

15. FILED Feb 3, 1929 — L. C. Obrock, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 1, 1929.

17. I HEREBY CERTIFY, That I attended deceased from October 18, 1928, to February 1, 1929, that I last saw him alive on February 1, 1929, and that death occurred, on the date stated above, at 8:20 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Abscess left lung.
107B
114B
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) - - - - - (to be sent later)
(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Unknown.
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Physical & Laboratory findings.
(Signed) G. W. Kiehnhoff, Medical Officer. M.D.
, 19 U.S. Veterans' Hospital, Jefferson Barracks 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 Sunset Burial Pk. — DATE OF BURIAL Feb 4 1929
20. UNDERTAKER Hauck & Schmitt — ADDRESS 3732 Gravois

MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County: St. Louis — Registration District No.: 1 2 3 — File No.:

Township: Carondelet — Primary Registration District No.: 6 2 4 8 B2 — Registered No.: 5-3

City: ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: Fred J. Kelsey

(a) Residence. No. 0 (Usual place of abode) St., 0 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: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Div

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)

PARENTS

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 Oct. 3, 1929. L. C. Obrock, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 1 1929

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:

abscess left lung

(1) Broncho Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY)

(duration) ..... 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?

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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

9681-S