

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

Do not use this space.

Russell

17833

File No. _____
Registered No. *396*
St. _____ Ward _____

1. PLACE OF DEATH

County *Greene* Registration District No. *318*
Township _____ Primary Registration District No. *5439*
City *Springfield* (No. *R.F.D. #2*)

2. FULL NAME

Sherman Kelly
(a) Residence, No. *R.F.D. #2* St. _____ Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept. 9 / 1857*
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
62 unknown

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Farmer*
(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) *Arkansas*

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

14. INFORMANT (Address) *Mrs Mary Kelly, Springfield Mo*

15. FILED *5-17-29* 19 *29* For *Sharp* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5/15* 19 *29*

17. I HEREBY CERTIFY, That I attended deceased from *Mich* 19 *29* to *May 12* 19 *29*, and that I last saw him alive on *May 12* 19 *29*, and that death occurred, on the date stated above, at *2:30 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer Prostate
SIC

CONTRIBUTORY *Exhaustion*
(SECONDARY) (duration) *1* yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? *Chemical*
(Signed) *Carl Russell*, M. D.

5/16 19 *29* (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 *Green Lawn* DATE OF BURIAL *5/17* 19 *29*

20. UNDERTAKER *Alma Johnson* ADDRESS *Springfield*

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.

JUN 2 1929 39 6 5

PARENTS

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DEC 17 1950

DEC 5 1943

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