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

Do not use this space.

34737

File No. 19

Registered No. 19

1. PLACE OF DEATH

County: Pulaski — Registration District No.: 711

Township: Union — Primary Registration District No.: 3940

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

2. FULL NAME Ray V Kelley

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-7-1928

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	1		12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) Hill City
(STATE OR COUNTRY) Kansas

PARENTS

10. NAME OF FATHER Willie B Kelley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Pearl Maxwell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

14. INFORMANT Willie B Kelley
(Address) Dixon Mo

15. FILED 10-23 1929 A S Lick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

✓

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-19-7th 1929

17.
I HEREBY CERTIFY, That I attended deceased from 10/18, 1929, to 10/19, 1929, (but I last saw him alive on 10-18, 1929, and that death occurred, on the date stated above, at 10/19-29 10-8 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchal Pneumonia
10/19/29
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Whooping Cough
..... (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) C. J. Crider, M. D
, 19 (Address) Dixon 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	DATE OF BURIAL
Stockton Cemetery	10/ 1929
20. UNDERTAKER	**ADDRESS**
Fred H Gilbert	Dixon 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD