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

Do not use this space.

852

1-8 1930

1. PLACE OF DEATH

County: Green

Township: Walnut Grove

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

Registration District No. 325

Primary Registration District No. 3450

File No. .....

Registered No. .....

2. FULL NAME Marion Duncan 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF ~~(OR) WIFE OF~~ Anna Laufenberger

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-13-1865

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	64	7	2	

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): Stockman

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kentucky (STATE OR COUNTY)

PARENTS

10. NAME OF FATHER Alexander Kelley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTY) Kentucky

12. MAIDEN NAME OF MOTHER Margaret McConnell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTY) Tenn.

14. INFORMANT Mrs. Robbie Kelley (Address) Ash Grove Mo.

15. FILED ....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan-15 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan-1 1930, to Jan 15 1930, that I last saw him alive on Jan 12 1930, and that death occurred, on the date stated above, at 9 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Rectum

Liver General Peritonitis

S.B.D.

S.B.D. (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 45

..... (duration) ..... 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? Microscopic

WHAT TEST CONFIRMED DIAGNOSIS? No

(Signed) S B Smith, M. D.

Jan-17-1930 (Address) Walnut Grove 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
Williamson Cemetery	Jan-17 1930
20. UNDERTAKER	**ADDRESS**
J A Brown Sons	Walnut Gr

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so properly classified.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Greene Registration District No. 325 File No.

Township Walnut Grove Primary Registration District No. 5450 Registered No.

City (No. , St. Ward)

2. FULL NAME Marion Duncan 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)
M	W	M

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 1-16-, 1930 F. M. Clark
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 15 1930

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:

(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

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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