

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

Do not use this space.

1235
226

1. PLACE OF DEATH

County Jackson
Township W
City Kansas City (No. Kansas City Gene Hosp)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. _____ (Ward)

2. FULL NAME

Kellen Infant
(a) Residence. No. 3500 Park St. _____ Ward. _____

(Usual place of birth) (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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 16, 1930

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

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

9. BIRTHPLACE (CITY OR TOWN) General Hosp
(STATE OR COUNTRY) Kansas City Mo.

10. NAME OF FATHER Wm J Keller

11. BIRTHPLACE OF FATHER (CITY OR TOWN) White Cloud
(STATE OR COUNTRY) Kansas

12. MAIDEN NAME OF MOTHER Emma Lindeman

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

14. INFORMANT Neura Clark
(Address) K C General Hosp

15. Jan 17, 1930 M. M. Conroe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-16 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-16, 1930, to 1-16, 1930
that I last saw him alive on 1-16, 1930 and that death occurred, on the date stated above, at 8:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Prematurity (5 1/2 - 6 mos)
159

CONTRIBUTOR (SECONDARY) 1610
(duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) P. S. Williams, M. D.
1-16, 1930 (Address) Gen Hosp

*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 Highland Park DATE OF BURIAL 17 1930

20. UNDERTAKER O. C. Mast ADDRESS 1415 East 15

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

