

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

Do not use this space.

Dr. G. Hodgson
8344
File No. _____
Registered No. 190
St. _____ Ward)

APR 28 1930

1. PLACE OF DEATH

County Green Registration District No. 318
Township _____ Primary Registration District No. 2001
City Springfield (No. 828)

2. FULL NAME

Robert Marshall Kaysell
(a) Residence. No. 828 State 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 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 7 86
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 68 8 20

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(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) _____

10. NAME OF FATHER Wm Chappell

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

12. MAIDEN NAME OF MOTHER Martha

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

14. INSURANCE _____ (Address) 828 State

15. FILED 3-5-30 Jan Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 1 1930
17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1930, to Mar 1, 1930, and that I last saw him alive on Mar 1, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

320 Arterio-Sclerosis
Myocarditis +
Pneumo-pneumonia
(duration) 2 yrs. mos. ds.
(duration) _____ yrs. mos. ds. 6 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) G. Hodgson, M. D.

*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.
reduced arts Bldg

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL 6 1930

20. UNDERTAKER Wm Chappell ADDRESS _____

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.

WHITE COPY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

