

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

Do not use this space.

21189

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File No. _____
Registered No. **6050**
St. _____ Ward _____

1. PLACE OF DEATH

County..... Registration District No. **791**
1003
Township..... Primary Registration District No. _____
City **St. Louis Mo.** (No. **3313**) **Lawton**

2. FULL NAME

Jess Kenley
(a) Residence. No. **3313 Lawton** St., **21** Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred **15** 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 col.	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (with the word) widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF widow		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known		
7. AGE YEARS about 38	MONTHS -	DAYS -
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Laborer (over 1000 lbs. labor) (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) **Tenn**

10. NAME OF FATHER **William H Kenley**

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

12. MAIDEN NAME OF MOTHER **Caroline Oliver**

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

14. INFORMANT **John E. Kenley**
(Address) **3313 Lawton Blvd**

15. FILED _____ 19____
Max C. Miller
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1. **1**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 18, 1930**

17. I HEREBY CERTIFY, That I attended deceased from **June 17, 1930** to **June 18, 1930**
that I last saw him alive on **June 18, 1930** and that death occurred, on the date stated above, at **10:10 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Myocarditis
93A
(duration) yrs. mos. **10** da.
CONTRIBUTORY (SECONDARY) **93B**
(duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **W. H. G. Clark** M. D.
6/19, 1930 (Address) **1635 Carr St**

*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 **Washington Park Cemetery** DATE OF BURIAL **6/23, 1930**

20. UNDERTAKER **Dunn Bros** ADDRESS **715 Jefferson Ave**

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.

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