

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

Do not use this space.

26618
3216

File No. _____
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH
County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1902
City Kansas City (No. 2630 Brooklyn) St. _____ Ward _____

2. FULL NAME William H. Kelly
(a) Residence. No. 2630 Brooklyn St. 11 Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs Anna M. Kelly

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 25 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
72 3 8

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

9. BIRTHPLACE (CITY OR TOWN) Aurora
(STATE OR COUNTRY) Illinois

10. NAME OF FATHER William C. Kelly

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

12. MAIDEN NAME OF MOTHER Catherine Dowd

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

14. INFORMANT Mrs Anna M. Kelly
(Address) 2630 Brooklyn Kansas City Mo

15. FILED 8/4 1930 M. M. Orpel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 3 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1930 to Aug 3 1930 that I last saw him alive on Aug 2 1930, and that death occurred, on the date stated above, at 3:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Spontaneous
apoplexy
while (up) asleep
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) none
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 48
IF NOT AT PLACE OF DEATH _____

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

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Wanda H. Leonard M. D.
8-4 1930 (Address) 3232 Summit

*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 Stanton Kansas DATE OF BURIAL Aug 6 1930

UNDERTAKER John J. Sheehan ADDRESS H. C. 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.

3232 Summit
Ofc and Res Ld 1523