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

Do not use this space.
29848

File No. 3653
Registered No.

1. PLACE OF DEATH
County: Jackson
Township: ~~Kaw~~
City: Kansas City (No. Sherman Hotel St. Ward)
Registration District No. 399
Primary Registration District No. 1802

2. FULL NAME Lucretia Eveland Kelsey
(a) Residence. No. Sherman Hotel 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)
Female	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Major S. E. Kelsey

6. DATE OF BIRTH (MONTH, DAY AND YEAR) February 8, 1871

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	59	6	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(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) Missouri

PARENTS
10. NAME OF FATHER Lewis B. Eveland
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Pennsylvania
12. MAIDEN NAME OF MOTHER Ruth MacMillan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Kentucky

14. INFORMANT Major S. E. Kelsey
(Address) Sherman Hotel

15. FILED 9/5, 1930 M. M. Crowe
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 4/17/30, 19, to 9/3/30, 19, that I last saw h. alive on 9/4/30, 19, and that death occurred, on the date stated above, at 11:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral hemorrhage
137A
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Paralysis agitans
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF 4/17/30
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Biopsy
(Signed) H. P. Caplin M. D.
9/4, 1930 (Address) 1500 Professional Bldg

*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~~ Elmwood Cemetery — DATE OF BURIAL 9-5-1930
20. UNDERTAKER Stine & McClure — ADDRESS 3235 Gillham Plaza

N. B.—Every ... should state CAUSE OF DEATH in plain terms, ... very important.

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 ..... Registration District No. 399 File No. .....

Township ..... Primary Registration District No. 1002 Registered No. 3659

City K. City (No. ..... St. ..... Ward)

2. FULL NAME Lucretia Eveland Kelsey

(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)
F	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 9/5 1930 M. M. Crowe
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 3 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:
Exhaustion
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Papillary Cyst Admonal Ovary ..... (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

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I. B.—Eve... of infor... be ... AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF ... at it may be pro... d. Exact statement of OCCUPATION is ve... ...ant.

REGISTRARS SHA... ...CATE ... LAW

1930
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