

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

Do not use this space.

21750

1. PLACE OF DEATH

County Jackson

Registration District No. 399

File No. _____

Township Kaw

Primary Registration District No. 1002

Registered No. 2000

City Kansas City (No. St. Healey Hospital)

St. 2008 (Ward)

2. FULL NAME

Walter Kellum

(a) Residence. No. 1002 Virginia Ward.

(Usual place of abode) Length of residence in city or town where death occurred 9 yrs. 7 mos. 7 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

Cauc

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

None

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

Oct. 17, 1904

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

26

8

9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Common Labor

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Texas

10. NAME OF FATHER

Walter R. Kellum

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Texas

12. MAIDEN NAME OF MOTHER

Essie Frisby

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Texas

14. INFORMANT

(Address)

Walter R. Kellum
1002 Virginia

15. FILED

7/1, 1931

M. W. Crow
asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

June 26 1931

17. I HEREBY CERTIFY, That I attended deceased from 6-11, 1931, to 6-26, 1931, that I last saw him alive on 6-26, 1931, and that death occurred, on the date stated above, at 1:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Hemorrhage
737
738 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

Pulmonary Tuberculosis (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory

(Signed) Geo. Ladonny, M. D.

727, 1931 (Address) 1518 E 15th

*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

Blue Ridge

July 2, 1931

20. UNDERTAKER

ADDRESS

Adkins Bros

2320 Michigan

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

