

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

Do not use this space.

27906 a

**1. PLACE OF DEATH**

County Douglas Registration District No. 974  
Township Spring Creek Primary Registration District No. 5382  
City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Isaac Kester  
(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 30 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-24-1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
76 9 28

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Farmer  
(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) Lawrence Co. Mo.

10. NAME OF FATHER William Kester

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

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

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

14. INFORMANT G. E. Kester (Address) Kansas

15. FILED 12-8-31 V. J. Mackey REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

3 16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 22<sup>nd</sup> 1931

17. I HEREBY CERTIFY, That I attended deceased from Sept 12<sup>th</sup> 1930, to Aug 27<sup>th</sup> 1931, that I last saw him alive on Aug 27<sup>th</sup> 1931, and that death occurred, on the date stated above, at 2:20 - a. m.

18. THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
519 Carcinoma of left  
520 Kidney

CONTRIBUTORY (SECONDARY) Poor Health and Paralysis (duration) 1 yrs. 6 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) G. C. Ellis M. D.  
1931 (Address) Rome, Mo.

\*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 Mt. Faber Cemetery DATE OF BURIAL Aug 23 1931

20. UNDERTAKER Clint King ADDRESS Wawa 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.

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**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 Douglas Registration District No. 974  
 Township Campbell Primary Registration District No. 5-387  
 City (No. St. Ward)

**2. FULL NAME**

Isaac Kester  
 (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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>wid</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>76</u>	MONTHS <u>9</u>	DAYS <u>28</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 22, 1931

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on ..... to ..... 19..... Death is said to have occurred on the date stated above, at ..... m.  
 The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance:  
 Date of onset

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
 If so, specify.....  
 (Signed)....., M. D.  
 (Address).....

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>
	13. NAME <u>William Kester</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>
	15. MAIDEN NAME <u>Angelina McClellan</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>
17. INFORMANT (ADDRESS)	
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE	
19. UNDERTAKER (ADDRESS)	
20. FILED <u>1-8</u> 19 <u>32</u> <u>D. G. Mackey</u> Registrar	

**SUPPLEMENTARY**

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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