25347

~~25447~~

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

1. PLACE OF DEATH

County: Bates — Registration District No. 52 — File No.

Township: West Boone — Primary Registration District No. 5080 — Registered No. 9

City: ~~Merwin~~ (No. ..... St. ..... Ward)

2. FULL NAME: Athelston O. Kelso

(a) Residence. No. ..... St., ..... Ward. (If nonresident give city or town and State)
(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.

SEP 21 1932

## PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 17, 1872

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 59 | 9 | 14 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cafe Operator 246

(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): Ill. 2

PARENTS

10. NAME OF FATHER: John Westley Kelso

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Il l

12. MAIDEN NAME OF MOTHER: Emsy Pritchard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unk 31

14. INFORMANT: Mrs Elizabeth Kelso
(Address): Merwin Mo.

15. FILED 8/2, 1932 E E Shockey REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 1 1932

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1932, to Aug 1, 1932, that I last saw him alive on July 31, 1932, and that death occurred, on the date stated above, at 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Essential Hypertension (duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Cerebral Hemorrhage (duration) ..... yrs. ..... mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? (1)

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Basil C Hartwell, M. D

, 19 (Address) Drexel 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. (See reverse side for additional space.)

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL |
|---|---|
| Sharron Cemetery | 9-2-32 19 |

| 20. UNDERTAKER | ADDRESS |
|---|---|
| Archer & Mangold Amsterdam | 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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**1. PLACE OF DEATH**

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., .....St. .....Ward)

**2. FULL NAME** .....

(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) |
|---|---|---|
| | | |

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. |
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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....., 19..... .....
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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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:

.....
.....
.....
.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.....ds.

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IF NOT AT PLACE OF DEATH?.....

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WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....,M. D
, 19 (Address)

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