

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

Do not use this space.

8181

1. PLACE OF DEATH

County Cass
Township Amelia
City..... (No. St. Ward)

Registration District No. 147
Primary Registration District No. 5210

File No.
Registered No. 4

2. FULL NAME

Mary A. Kelley

(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 1 yrs. 8 mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 1 - 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 2 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Nurse

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

13. NAME Margaret Hanley

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

15. MAIDEN NAME Nora Keating

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT Leg Hanley (ADDRESS) Harrisonville, Mo. 3

18. BURIAL, CREMATION, OR REMOVAL PLACE Catholic DATE 3/18, 1934

19. UNDERTAKER Brunnenburger Bros (ADDRESS) Harrisonville Mo.

20. FILED 3/16, 1934 D. B. B. Jones Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 15, 1934

22. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1934, to March 15, 1934
I last saw her alive on March 15, 1934 Death is said to have occurred on the date stated above, at 6:58 P.M.

The principal cause of death and related causes of importance were as follows:
Osteo Sarcoma

Date of onset
530
531
Other contributory causes of importance:

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?

(Signed) J. W. Scott, M. D.
(Address) Harrisonville Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

187 Seal



**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 Cass
Township Justin
City (No. St. Ward)

Registration District No. 147
Primary Registration District No. 5210

File No.
Registered No. 4

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 7 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) w

6A. 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. 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.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED

(B.B. Tanti) Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 15 1934

22. I HEREBY CERTIFY, That I attended deceased from Nov 8 - 1933 to March 15 1934
I last saw him alive on March 12, 1934 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:

Obstetrical carcinoma of the cervix noted by me Nov - 1933
It is my best opinion it originated in tubo-ovary, Lumbosacral

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) *J. B. Scott*, M. D.
Harrisonville Mo
(Address).....

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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