

JUL 1 1935

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

Do not use this space.

21877

1. PLACE OF DEATH

County Stones
Township Washington
City Galena (No.)

Registration District No. 843
Primary Registration District No. 6106

File No.
Registered No.
St. Ward

2. FULL NAME

Catharine D. Kelly

(a) Residence, No. Galena mo 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 Female 4. COLOR OR RACE white 5. ~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-11-1883

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
51 6 29

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. hwt
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) Blakesburg Iowa

FATHER 13. NAME Simon Ocuturf

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

MOTHER 15. MAIDEN NAME Lida Masty

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

17. INFORMANT (ADDRESS) Mrs. Frank Kelly

18. BURIAL, CREMATION, OR REMOVAL PLACE Mass Hill DATE 6-11-1935

19. UNDERTAKER (ADDRESS) Dr. Hunt

20. FILED June 11, 1935 Nellie H. Trandy Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-10-1935

22. I HEREBY CERTIFY, That I attended deceased from her 1935 to June 10 1935
I last saw her alive on June 10 1935. Death is said to have occurred on the date stated above, at 10 a. m.
The principal cause of death and related causes of importance were as follows:

Apparent
Other contributory causes of importance:
Fracture of hip
8-7-35

Date of onset
6-10-35

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

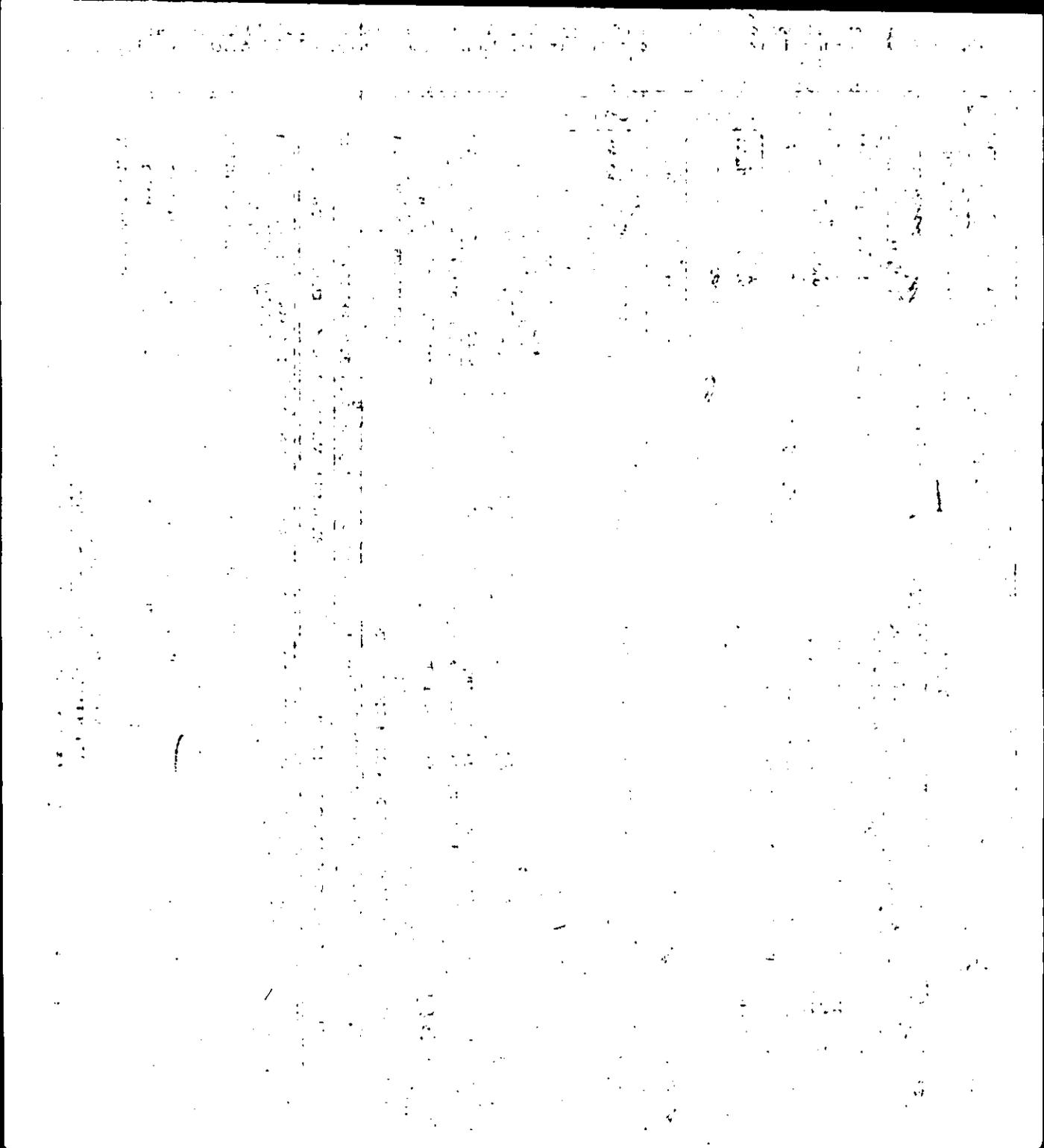
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Falls
Nature of injury Fracture of hip

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) [Signature] M. D.
(Address) [Address]

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 Stone
Township Washington
City (No.)

Registration District No. 843
Primary Registration District No. 6106

File No.
Registered No.
St. Ward

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 10, 1935

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

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 .

I last saw h. alive on , 19 . Death is said to have occurred on the date stated above, at m.

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, or 81 7 29

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

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) (If Total time (years) spent in this occupation)

Apoplexy
Victim high blood pressure
Fracture of left femur caused from fall on door step
Date of onset

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

Other contributory causes of importance: Fracture of left femur caused from fall on door step

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE , 19

19. UNDERTAKER (ADDRESS)

20. FILED 6/11, 1935 Nellie Irons Registrar

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? on doorstep at home galena mo (Specify city of town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. home

Manner of injury fall
Nature of injury fracture left femur

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. W. Young, M. D.

(Address)

Exact statement of OCCUPATION is very important.

AUG 6 1935

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