

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.

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

44872

Do not use this space.

1. PLACE OF DEATH

(a) County Worth Registration District No. 903
(b) Township Grant City, Mo. Primary Registration District No. 4545 Registered No. _____
(c) City Grant City, Mo. (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. ☐ (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 90/7/81

7. AGE YEARS 57 MONTHS 4 DAYS 26 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Lawyer
9. Industry or business in which work was done, as 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) Grundy County, Mo.

13. NAME Alexander W. Kelso

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Grundy County, Mo.

15. MAIDEN NAME Frances Linney

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Grundy County, Mo.

17. INFORMANT (ADDRESS) Vera R. Kelso
Grant City, Mo.

18. BURIAL, CREMATION OR REMOVAL PLACE Grant City, Mo. DATE 12/27/38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Melvin B. Hays
Grant City, Mo.

20. FILED 1-7 19 39 Red Mull M.D.
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 26-DEC 19 38

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

I last saw him alive on Dec 25 19 38 Death is said to have occurred on the date stated above, at 4:15 p.m.

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

Cerebral Hemorrhage
Very sudden
Fatty Heart
Date of onset 924

Other contributory causes of importance: Heavy Phos Derisor

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? No 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? No

If so, specify _____

(Signed) John Anderson M. D.

(Address) Grant City, Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.