DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42478

JAN 13 1940

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4887

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town RURAL (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Kansas City Tb. Hosp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Hosp. - Since 3 da (Specify whether
In this community 4 Syrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 3915 Tracy (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME Timothy Kelly
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Ma
5. Color or race Wh
6. (a) Single, widowed, married, divorced Married.
6. (b) Name of husband or wife Annie Kelly
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased 1 (Month) 31 (Day) 1867 (Year)

8. AGE: Years 72 Months 1 Days 25 If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Iowa (State or foreign country)
10. Usual occupation Carpenter
11. Industry or business
MOTHER FATHER
12. Name Timothy Kelly
13. Birthplace ____ (City, town, or county) IRELAND (State or foreign country)
MOTHER
14. Maiden name MARY O'Toole
15. Birthplace ____ (City, town, or county) IRELAND (State or foreign country)
16. (a) Informant's own signature Hosp. Records.
(b) Address TB Hospital
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-39 (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cemetery
18. (a) Signature of funeral director Thos. E. Quirk
(b) Address 4316 Troost
19. (a) Dec 27, 1939 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 25 year 1939 hour 11½ minute P. M.
21. I hereby certify that I attended the deceased from July 22, 1939, to Dec 25, 1939; that I last saw him alive on 12-25-, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Far advanced Pulmonary Tuberculosis	2 yrs
Due to 23	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature [signature] (M. D. or other)
Address Kansas City Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

WHITE PAPER — USE CARBON PAPER FOR ALL COPIES. PRINT ALL ITEMS. Write in ink. Do not use pencil.
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.

I X19511

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 wit the above constitutes grounds for revocation of license.)

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