

FILED FEB 26 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **1113**
Registrar's No. **98**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson,**
(b) City or town **Kansas City,**
(c) Name of hospital or institution:
1816 East 47th Terrace,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Unknown,**
In this community **132 yrs.**
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. **1816 East 47th Terrace,**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **X** years.

3. (a) PRINT FULL NAME **Mrs. Josephine Kelley,**
(b) If veteran, name war **No**
(c) Social Security No. **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **January** day **7th**
year **1940** hour **4:00** minute **A.** M.

4. Sex **Female**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **L. E. Kelley,**
6. (c) Age of husband or wife if alive **X** years
7. Birth date of deceased **January 26, 1863,**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Dec. 26, 1939,**
to **Jan 7, 1940,**
that I last saw her alive on **Jan 7, 1940,**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
76 11 11 hr. min.

Immediate cause of death **Cerebral apoplexy**
Due to **Hypertension**
Duration **1-7-40**

9. Birthplace **Ohio,**
(City, town, or county) (State or foreign country)

Other conditions **Stroke a year earlier**
(Include pregnancy within 3 months of death)

10. Usual occupation **at home,**
11. Industry or business **X**
MOTHER FATHER
12. Name **Sturm, Elias**
13. Birthplace **Ohio,**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown,**
15. Birthplace **Ohio,**
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: **None**
Of operations
Of autopsy **None**
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature **W. Harold Kelley,**
(b) Address **503 Myrtle Ave., Kansas City, Mo.**
17. (a) **removal** (b) Date thereof **1-8-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Sidney, Ohio.**
18. (a) Signature of funeral director **Stine & McClure,**
(b) Address **3235 Gillham Plaza, K. C., Mo.**
19. (a) **Jan. 8, 1940** (b) **M. M. Crave**
(Date received local registrar) (Registrar's signature)

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?
While at work? (Specify type of place) (3) Means of injury
23. Signature **John P. Lewis, M.D.** (M. D. or other)
Address **1346 Indiana** Date signed **1-8-40**

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.

Dr. John R. Lewis.

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 J. B. Waters

Licensed Embalmer No. 3992

P. O. Address K C Mo

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.