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

23003
Do not use this space.

JUL 15 1940

1. PLACE OF DEATH
(a) County Sullivan — Registration District No. 852
(b) Township Polk — Primary Registration District No. 4518 — Registered No.
(c) City Milan — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 Louis Lester Kelley
(a) Residence, No. ..... St. ..... (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
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: Unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Feb 17, 1904
7. AGE: YEARS 36 — MONTHS 2 — DAYS 20 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Mechanic
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): Seymour Iowa

FATHER
13. NAME: Louis Oliver Kelley
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Milan, Mo

MOTHER
15. MAIDEN NAME: Stella Davis
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unionville Mo

17. INFORMANT (ADDRESS): Oliver Kelley Milan, Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE: Oak Grove DATE: 5-8 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Ligan & Son Milan Mo
20. FILED: July 1, 1940 Leo Hagan Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 7, 1940

22. I HEREBY CERTIFY, That I attended deceased from January, 1939, to ~~April~~ May 6, 1940
I last saw him alive on April 6, 1940. Death is said to have occurred on the date stated above, at 2:30 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Myocarditis	
23	

Other contributory causes of importance:
Chronic Diabetes
Gastric Ulcer
Pulmonary T B

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) Quinn H. Becker M.D.O
(Address) Milan Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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 importan

50M-1-12-38 1 X14028

District Number No. 10

District File Number 7-40-1410

Date Filed JUL 11 1940

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 Russell C Riggin

Licensed Embalmer No. 3792

P. O. Address Milan 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.

. S. No. 2B
M—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23003

Registration District No. 852 Primary Registration District No. 45-18 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Milan (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan

(c) City or town Milan (If outside city or town limits write "RURAL")

(d) Street No. ✓ (If rural, give location)

(e) If foreign born, how long in U. S. A.? ✓ years.

3. (a) PRINT FULL NAME Louis Lester Kelley

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Div

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 36 Months 2 Days 20 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Aug 28/40 (Date received local registrar) (b) Cleo Hagan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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 Jim H Becham Do (M.D. or other)

Address Milan Mo Date signed

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