

Registration District No. 85

Primary Registration District No. 1001

State File No. \_\_\_\_\_

Registrar's No. 769

1. PLACE OF DEATH:

(a) County BUCHANAN <sup>2</sup>

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

(c) Name of hospital or institution:  
2922 LAFAYETTE-STR.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 8 YRS. \_\_\_\_\_ (years, months or days) \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BUCHANAN

(c) City or town ST-JOSEPH  
(If outside city or town limits, write "RURAL")

(d) Street No. 2922 LAFAYETTE-ST.  
(If rural, give location)

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

3. (a) PRINT FULL NAME WILLIAM-O-KELLEY

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17  
year 1940 hour 3:15 minute A. M.

21. I hereby certify that I attended the deceased from 7-15-40  
\_\_\_\_\_, 19\_\_\_\_, to 7-17-40, 19\_\_\_\_.

4. Sex Male 5. Color W hl

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

6. (b) Name of husband or wife \_\_\_\_\_

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

that I last saw him alive on 7-15-, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Chr. myocarditis

7. Birth date of deceased Oct 25 1855  
(Month) (Day) (Year)

Duration Several months

8. AGE: Years 84 Months 8 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Senility A3C

Due to Secondary Anemia Long Anemia

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

Other conditions Generalized arteriosclerosis  
(Include pregnancy within 3 months of death)

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name George Kelley Mrs.

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

14. Maiden name Elizabeth Tate

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Helen Haynes

(b) Address 4701 Place of CMSO

17. (a) burial (b) Date thereof 7-19-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethel-Cosby Miss.

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? 45

18. (a) Signature of funeral director Wm Stanley

(b) Address St Joseph Miss

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

19. (a) 7-17-1940 (b) W. Testa  
(Date received local registrar) (Registrar's signature)

23. Signature McGrims (M. D. or other) 1

Address St Joseph. Mo Date signed 7/17/40

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

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, <sup>and</sup> or by Edric K Jones, Registered Apprentice No. 246 working under my personal supervision.

Signed

John H. Hurley

Licensed Embalmer No. 4058

P. O. Address St Joseph 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, fact should be so stated above.