

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

32225
95

State File No. _____

Registration District No. 100 OCT 28 1940

Primary Registration District No. 5558

Registrar's No. 5358

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Martin City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
110th & Wornall Rd apt
(If not in hospital or institution, write street number or location) 3
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 50 Years
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. 5408 Rockhill Road
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT

FULL NAME Mr. Roscoe Addington Kelly

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Anna C. Kelly 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased December 23 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 8 27 hr. min.

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

10. Usual occupation Grain Broker

11. Industry or business Kelly Grain Company

12. Name James Kelly

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

14. Maiden name Unknown Addington

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

16. (a) Informant W. Kelly

(b) Address 5408 Rockhill Rd

17. (a) Burial (b) Date thereof Sept. 21, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial of cremation Calvary Cemetery

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 10-7-40 (b) R. V. Lindsey, Jr.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19th
year 1940 hour 11 minute 05 A.M.

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

Immediate cause of death Carbon Monoxide Poisoning
Due to Inhaled Motor Car exhaust fumes

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy See above

Duration _____
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) Suicide
(b) Date of occurrence 9/19/40

(c) Where did injury occur 110th & Wornall in car
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
36th Ave Street
While at _____ (Specify type of place) (e) Means of injury 9/19/40

23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed _____

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

MOTHER FATHER

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

K.C. Mc...

Licensed Embalmer No. *21043*

P. O. Address *K.C. Mc...*

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.