

Registration District No. 625-

Primary Registration District No. 5827

Registrar's No. 66

1. PLACE OF DEATH:

(a) County Nodaway  
 (b) City or town Maryville Rural  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
2 mi S. 1/4 mi East.  
 (If not in hospital or institution, write street number, or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community 2 1/2 yrs.  
 years, months or days (Specify whether)

8. (a) PRINT FULL NAME F. C. Kelly  
 (b) If veteran, name war no  
 (c) Social Security No. none

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Kate Amelia Kelly 6. (c) Age of husband or wife if alive 68 years  
 7. Birth date of deceased Nov. 15, 1870.  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>4</u>	<u>20</u>	hr. _____ min.

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

10. Usual occupation Farmer

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

MOTHER FATHER  
 12. Name Samuel Kelly  
 13. Birthplace not known  
 (City, town, or county) (State or foreign country)  
 14. Maiden name not known  
 15. Birthplace not known  
 (City, town, or county) (State or foreign country)

16. (a) Informant Jake Sutterlin  
 (b) Address Maryville Mo.

17. (a) Burial (b) Date thereof May 7, 1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: Burial or cremation Graham Mo.

18. (a) Signature of funeral director John W. Price  
 (b) Address Maryville Mo.

19. (a) May 7-41 (b) Mattie E. Clardy  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Nodaway  
 (c) City or town Maryville Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2 mi S. 1/4 mi East.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 4  
 year 1941 hour 7 minute p. M.

21. I hereby certify that I attended the deceased from March, 1932, to April, 1941  
 that I last saw him alive on Nov 28, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Sclerosis Duration 9 yrs

Due to General arteriosclerosis

Due to \_\_\_\_\_

Other conditions 44 W  
 (Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations: \_\_\_\_\_  
 Of autopsy: \_\_\_\_\_  
 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 Dr. Blemer (M. D. or other) \_\_\_\_\_  
 Address Maryville Date signed 5/16/41

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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*John W. Price*

Licensed Embalmer No. 3229

P. O. Address Maryville 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18582

Registration District No. 625

Primary Registration District No. 5827

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Nodaway Twp  
(b) City or town Castana Twp  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Frank C. 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 W

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 70 Months 4 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 \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 5-7-41 (b) Manie E. Clardy  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 \_\_\_\_\_ Duration \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature J. A. Blomquist (M. D. or other)

Address Manlyville Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

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

S-18582.