

Registration District No. 43

Primary Registration District No. 5135

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Fisk, Rural, Ash Hill 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 40 years  
years, months or days

3. (a) PRINT FULL NAME Mary Elizabeth Kelly

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife W. F. Kelly 6. (c) Age of husband or wife if alive 86 years

7. Birth date of deceased June 22 1886  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>6</u>	<u>26</u>	hr. _____ min. _____

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

10. Usual occupation housewife

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

MOTHER FATHER { 12. Name Tom Davidson

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

14. Maiden name Mary Jane Davis

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

16. (a) Informant Rena Dabbs

(b) Address Fisk, Mo.

17. (a) burial (b) Date thereof 1-19-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ash Hill

18. (a) Signature of funeral director Marshall S. Phain

(b) Address Fisk, Missouri

19. (a) 1-19-43 (b) Belle Kimmel  
(Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler  
(c) City or town Rural- Ash Hill Twp  
(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 Jan day 18  
year 1943 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from April  
1942 to Jan 18 1943

that I last saw her alive on Jan 18 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure Duration

Due to Senility

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_ PHYSICIAN \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Gordon C. Campbell M. D. or other 90  
Address Fisk, Mo. Date signed 1/19/43

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

RECEIVED

District Health Office No. 2,

District File Number 243-136

Date Filed 2-3-43

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1708  
Registrar's No. 20-

Registration District No. 43 Primary Registration District No. 513d-

1. PLACE OF DEATH: Bubler  
(a) County  
(b) City or town Rural  
(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)

3. (a) PRINT FULL NAME Mary Elizabeth Kelly  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex ♀ 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased June 22  
(Month) (Day) (Year)

8. AGE: Years 86 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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) (Place: burial or cremation)

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

(b) Address \_\_\_\_\_  
19. (a) 8/20/43 (b) Belle Kinne  
(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 July Year 1943 Day \_\_\_\_\_ Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death Heart Failure Duration \_\_\_\_\_

Due to Senility

Due to Chronic endocarditis

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
922

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)  
(b) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature Gordon H. Campbell (M. D. or other) MD  
Address Frank Mo Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

[The page contains extremely faint and illegible text, likely bleed-through from the reverse side of the document. The text is arranged in several columns and is mostly unreadable.]