

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 758

BUREAU OF THE CENSUS
LED FEB 27 1943

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Trinity Lutheran
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Three Weeks (Specify whether years, months or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 8715 Wilson Road (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Kate Berry Kelley

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

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

6. (b) Name of husband or wife W.R. Kelley 6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased February 17 1874
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days 26 If less than one day 25 hr. _____ min. _____

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

10. Usual occupation House Wife

11. Industry or business

12. Name John James Fisher
13. Birthplace Harrison Co Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Anna
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Walter R. Kelley

(b) Address 8715 Wilson Road K.C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-43
(Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah, K.C. Mo

18. (a) Signature of funeral director W. Mitchell

(b) Address 310 N. Main St. Independence, Mo

19. (a) 2-13-43 (Date received local registrar) (b) W. M. Grove (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 12 year 1943 hour 9 minute 4 M.

21. I hereby certify that I attended the deceased from Jan 22 1943 to Feb 12 1943 that I last saw her alive on Feb 11 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis (chronic) Chronic valvulitis Acute pericarditis
Due to 93

Duration
2 wks
2 wks
2 wks

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 Albin L. Stewart (M. D. or other) _____

Address 1100 Park Blvd 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 me

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

working under my personal supervision.

Signed George G Mitchell

Licensed Embalmer No. 3925

P. O. Address Indep 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.