S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6160

FILED FEB 24 1949

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 665

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: KC G.H.O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community unk
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson 48 3
(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")
(d) Street No. 5 W. 6th St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME JAMES KELLY
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased unk (Month) (Day) (Year)

8. AGE: Years 67 Mos. Months Days If less than one day hr. min.
9. Birthplace unknown (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Coroners office
(b) Address Court House
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-9-44 (Month) (Day) (Year)
(c) Place: burial or cremation K.C. Dental College
18. (a) Signature of funeral director Mkapetius
(b) Address KC
19. (a) 2-9-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26 year 1944 hour 10 minute 20 P.M.
21. I hereby certify that I attended the deceased from 19 , to , 19 ;
that I last saw h alive on Arrow , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Arteriosclerotic heart	
Due to disease	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 93d	
Of autopsy Inspection & testing	

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?
(Specify type of place)
While at work? (e) Means of injury 0
23. Signature O. Veth (M.D. or other) 2/9/44
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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. 4273

P. O. Address. K C 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.