

FILED OCT 24 1944

Registration District No. 109

Primary Registration District No. 1002

Registrar's No. 4150

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: St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community 4 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Jackson
(c) City or town Wlathe 999
(If outside city or town limits, write "RURAL") 14
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME

Samuel J. Kelly

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

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

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

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years about 76 Months Days If less than one day hr. min.

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

10. Usual occupation Surgeon

11. Industry or business Surgeon

12. Name

13. Birthplace unknown (City, town, or county) (State or foreign country) 9

14. Maiden name

15. Birthplace unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Russell's Funeral Home
(b) Address Wlathe Kansas

17. (a) removal (Burial, cremation, or removal) (b) Date thereof Oct 14-44
(Month) (Day) (Year)
(c) Place: burial or cremation Wlathe Kans

18. (a) Signature of funeral director Russell's Funeral Home
(b) Address Wlathe Kansas

19. (a) 10-14-44 (b) J. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14th
year 1944 hour 5:10 minute 9 A. M.
21. I hereby certify that I attended the deceased from October 11th 1944, to October 15, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 4 days

Due to Arteriosclerosis, hypertension, etc.

Due to 8301

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

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?

23. Signature Wm. V. Brown M.D. (M. D. or other)
Address 207 Plaza, Miss. Bldg, Klaty, Mo. Date signed 10/14/44

4838
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.....

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.