

S. No. 2
DM-5-43
v. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37945

State File No.

291

FILED DEC 12 1944

Registration District No.

Primary Registration District No.

3026

Registrar's No.

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town INDEPENDENCE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1300 W. LEXINGTON
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 39 YEARS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 47
(c) City or town INDEPENDENCE 4
(If outside city or town limits, write "RURAL") 4
(d) Street No. 1300 W. LEXINGTON
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. CATHERINE B. KELLEY
(b) If veteran, name war NO
(c) Social Security No. NO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 21
year 1944 hour 7 minute 00 P. M.
21. I hereby certify that I attended the deceased from Nov. 16
1944 to Nov. 21 1944
that I last saw her alive on Nov 21 1944
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife EDMOND L. KELLEY
6. (c) Age of husband or wife if alive XXXXX years
7. Birth date of deceased 11 9 1853
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage - basal
Due to Hy pertension
Due to 83a
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: no operation
Of autopsy no autopsy

Duration

2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day
91 0 12 hr. min.

9. Birthplace MONROE COUNTY IOWA
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business NONE

12. Name JOHN BISHOP

13. Birthplace NO RECORD
(City, town, or county) (State or foreign country)

14. Maiden name MARY J. HUMSTON

15. Birthplace NO RECORD
(City, town, or county) (State or foreign country)

16. (a) Informant J. STANLEY KELLEY

(b) Address 1707 DRUMM AVE.

17. (a) BURIAL (b) Date thereof 11-24-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MOUND GROVE

18. (a) Signature of funeral director Henry W. Stahl
(b) Address 815 W. MAPLE AVE.

19. (a) 11-23-1944 (b) James W. Ross
(Date received local registrar) (Registrar's signature)

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 C. Allen M.D. (M. D. or other)
Address Independence Mo Date signed 11-22-44

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

1-2
4
4

1163

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

Lyle M. Davis

Licensed Embalmer No.

3156

P. O. Address

Independence 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.