

FILED NOV 14 1945

Registration District No.

Primary Registration District No. 1002

Registrar's No. 4468

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:
701 - Bennington Ave 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community 55 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 701 - Bennington Ave 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

MARY ELLen Kelly

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
Philip T. Kelly

6. (c) Age of husband or wife if alive in years

7. Birth date of deceased

Sept 22 1863

(Month) (Day) (Year)

8. AGE:

Years 82

Months 1

Days 7

If less than one day hr. min.

9. Birthplace

Adrian Mich

(City, town, or county) (State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

Home

MOTHER FATHER

12. Name

James Hildriff

13. Birthplace

Adrian Michigan 1

14. Maiden name

Bridget Quentan

15. Birthplace

Park Ill 1

16. (a) Informant

W M Kelly

(b) Address

701 - Bennington Ave

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Oct 31 - 45

(c) Place; burial or cremation

Mt St Marys

18. (a) Signature of funeral director

[Signature]

(b) Address

Kansas City

19. (a) 10-30-45

(Date received local registrar)

(b) [Signature]

[Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 29 year 1945 hour 4 minute 20 A.M.

21. I hereby certify that I attended the deceased from May 15 1945 to Oct 29 1945 that I last saw h alive on and that death occurred on the date and hour stated above.

Immediate cause of death

Arteriosclerosis

Due to

Hypertension

Due to

Stroke of Brain

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

2 1/2

3 1/2

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)

(c) Means of injury

Signature

[Signature]

(M. D. or other)

Address

5242 [Address]

Date signed 10/28/45

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. 35257

P. O. Address 150 W

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....