

FILED OCT 19 1945 STANDARD CERTIFICATE OF DEATH

State File No. 33027

Registration District No. 13

Primary Registration District No. 3003

Registrar's No. 80

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Monett
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Vincent Hospital
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution 5 days
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town Preece City Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Walnut
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Michael T. Kelley

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife Mary Kelley 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 10 1884
(Month) (Day) (Year)

8. AGE: 61 Years 3 Months 17 Days If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Michael E. Kelley
13. Birthplace Utica N.Y.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Reardon
15. Birthplace Utica N.Y.
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Kelley
(b) Address Preece City Mo.

17. (a) Burial (b) Date thereof Sept. 29.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Patrick

18. (a) Signature of funeral director
(b) Address Cassville Mo.

19. (a) 9-29-45 (b) W. M. West
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 27 year 45 hour 4 minute 20 P.M.

21. I hereby certify that I attended the deceased from Sept 22 1945 to Sept 27 1945 that I last saw him alive on Sept 27 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Hemiplegia

Due to: Atherosclerosis

Due to:

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations: Of autopsy:

Duration 5 days
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) (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

23. Signature: Frank Kelley (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)
Address: Monett Mo. Date signed 9/29/45

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

MOTHER, FATHER

RECEIVED

District Health Officer No. 6

District File Number 1045-1027

Date Filed OCT 15 1945

SEP 11 1950

DEC 31 1945

OCT 8 1945

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..... *J. E. Cohen*.....

Licensed Embalmer No. 3584.....

P. O. Address Cassville 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1102
Registrar's No. 80

Registration District No. 13 Primary Registration District No. 3003

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

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Monett
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Michael T. Kelley

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day 27
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mary Kelley

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

7. Birth date of deceased June 10
(Month) (Day) (Year)

8. AGE: Years 61 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

Due to _____

Due to _____

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? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

OCT 8 1945

33027