S. No. 2
M—2-43
5-17-39
I X35697

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

Dr. Campion

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 12 1945

State File No. 37222

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 980

39
2
6

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield, (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 840 S. Grant (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: None (Specify whether
In this community: 20 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene 39
(c) City or town: Springfield, (If outside city or town limits, write "RURAL") 2
(d) Street No.: 840 S. Grant (If rural, give location) 6
(e) Citizen of foreign country? n (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: William J. Kelley
3. (b) If veteran, name war: Unknown
3. (c) Social Security No.: Unknown
4. Sex: Male n
5. Color or race: White
6. (a) Single, widowed, married, divorced: 2 Widowed
6. (b) Name of husband or wife: Mrs. Annie Kelley
6. (c) Age of husband or wife if alive: Unknown years
7. Birth date of deceased: September (Month) 1, (Day) 1866 (Year)

8. AGE: Years 79 Months 2 Days 27 If less than one day hr. min.

9. Birthplace: Unknown (City, town, or county) Kentucky 1 (State or foreign country)
10. Usual occupation: Postal Employee
11. Industry or business: Retired
MOTHER FATHER
12. Name: UNK.
13. Birthplace: UNK. (City, town, or county) UNK. 9 (State or foreign country)
14. Maiden name: UNK.
15. Birthplace: UNK. (City, town, or county) UNK. 9 (State or foreign country)
16. (a) Informant: Mrs. Lester Stuart
(b) Address: Springfield, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 30, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: East Lawn Cemetery
18. (a) Signature of funeral director: Alma Lohmeyer Funeral Home
(b) Address: Springfield, Missouri
19. (a) 11-29-45 (Date received local registrar) (b) E. W. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 28th, year 1945 hour 5:00 minute A. M.
21. I hereby certify that I attended the deceased from 1941, 19..., to November 5 1945 that I last saw him alive on Sept 16 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Infirmities of the aged	5 yrs
Due to: Hypertensive heart disease	10 yrs
Due to: Arterial Hypertension	20 yrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: ✓
Of autopsy: 950

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
23. Signature: William H. Campion (M. D. or other) D.O.
Address: Springfield, Mo. Date signed 11-29-45

984 (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. 3048

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.