

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36660**
Registrar's No. **4893**

FILED DEC 14 1948

Registration District No. **149**

Primary Registration District No. **1002**

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:
GENERAL HOSPITAL # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 das, 22 hrs, 25 mins**
(Specify whether
In this community **9 years and 10 months**
years, months or days)

3. (a) PRINT FULL NAME **VINIE KELLY**

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

4. Sex **3 FEMALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **2 WIDOWED**
6. (b) Name of husband or wife **John Kelly** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **September 10, 1889**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	59	2	18	hr. min.

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

10. Usual occupation **AT HOME**

11. Industry or business

MOTHER FATHER {
12. Name **UNKNOWN** 7
13. Birthplace **UNKNOWN**
14. Maiden name **UNKNOWN** 9
15. Birthplace **UNKNOWN** 7
(City, town, or county) (State or foreign country)

16. (a) Informant **Daughter: Maud Lee Swain**

(b) Address **2312 East 14th Street**

17. (a) **Burial** (b) Date thereof **12/1/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Highland Cemetery**

18. (a) Signature of funeral director **William Bros.**

(b) Address **1729 9th Street**

19. (a) **11-30-48** (b) **Theralline Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON** 48
(c) City or town **KANSAS CITY** 2
(If outside city or town limits, write "RURAL") 5
(d) Street No. **2312 East 14th Street**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOVEMBER** day **28th**
year **1948** hour **5:40** minute **P.** M.

21. I hereby certify that I attended the deceased from **NOVEMBER 25, 1948** to **NOVEMBER 28, 1948**
that I last saw her alive on **NOVEMBER 28th**, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death **CARDIO-RESPIRATORY FAILURE due to C. V. A. due to HYPERTENSIVE TYPE OF HEART DISEASE** Duration

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **93 2** 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 **E. Frank** (Specify type of place) Means of injury **Ellis**
23. Signature **E. Frank** (M. D. or other) **Ellis**
Address **600 East 22nd Street** Date signed **11/29/48**

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.