

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

FILED JAN 31 1949

Registration District No. **43**

Primary Registration District No. **3007**

Registrar's No. **28**

1. PLACE OF DEATH:

(a) County **Butler**
 (b) City or town **Papier Bluff**
 (c) Name of hospital or institution: **Papian Baptist Hosp.**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 hrs.**
 (Specify whether **life.**)
 In this community **life.**
 years, months or days

3. (a) PRINT FULL NAME **JANICA FAYA KELLY**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **No.**

4. Sex **FEMALE** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife **input**
 6. (c) Age of husband or wife if alive **1** years
 7. Birth date of deceased: (Month) (Day) (Year)

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

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

10. Usual occupation **Child.**

11. Industry or business

MOTHER FATHER {
 12. Name **LLOYD KELLY**
 13. Birthplace **MALDEN, Mo.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **VELA-FRANCIS NILES**
 15. Birthplace **NEW MADRID Co., Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Lloyd Kelly**
 (b) Address **0 MALDEN, Mo.**
 17. (a) **Burial** (b) Date thereof **5-7-48**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **NEW MADRID Cemetery**

18. (a) Signature of funeral director **Lloyd Russell**
 (b) Address **Piggott, Mo.**
 19. (a) **1-20-49** (b) **Strunetski**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **NEW MADRID**
 (c) City or town **MALDEN, Mo.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **9**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes/No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **7**
 year **1948** hour **4** minute **35 P.M.**
 21. I hereby certify that I attended the deceased from **2:00 PM, 5-7, 1948**, to **4:00 PM, 5-7, 1948**
 that I last saw her alive on **5-7, 1948**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Cardiac Dilatation, acute**
Pneumonia bronchial acute
Gastro-Enteritis, acute
 Due to **HAI**
 Other conditions: (Include pregnancy within 3 months of death)

Duration **Unknown**
Unknown
Unknown

Major findings: **107**
 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? (Specify type of place)
 (e) Means of injury
 23. Signature **W. J. Jones** (M. D. or other)
 Address **Papier Bluff, Mo.** Date signed **1-20/49**

RECEIVED

District Health Office No.

District File Number 149-1

Date Filed 1-24-5

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.