

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33660**
4657

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 4 yrs.		d. STREET ADDRESS (If rural, give location) 2554 Tracy	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2554 Tracy			

3. NAME OF DECEASED (Type or Print) a. (First) Sammie b. (Middle) Kelso c. (Last) Kelso			4. DATE OF DEATH (Month) (Day) (Year) Oct. 29 51		
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5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 31-1923	9. AGE (In years last birthday) 27	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Springfield Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Samuel Hams	13b. MOTHER'S MAIDEN NAME Minnie Beasley	14. NAME OF HUSBAND OR WIFE Andrew Kelso
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Andrew Kelso	ADDRESS 2554 Tracy K.C. Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Failure		cause not determined
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Eclampsia DUE TO (c) Miscarriage (3-11-51)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Retained Placenta			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 6520	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 10-28-1951, to 10-29-1951, that I last saw the deceased alive on 10-29-1951, and that death occurred at 11:30 AM, from the causes and on the date stated above.

23a. SIGNATURE J. R. Williams <i>J. R. Williams, M.D.</i>	(Degree or title)	23b. ADDRESS 2636 Brooklyn Ave	23c. DATE SIGNED 10/30/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 5	24b. DATE 11-1-51	24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Kans
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DATE REC'D BY LOCAL REG. 11-1-51	REGISTRAR'S SIGNATURE Deraldine Holmes	ADDRESS Kansas City, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NO. 300
0-48

FILED NOV 10 1951

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Clyford L Woods*

Licensed Embalmer No. *3106*

P. O. Address *1520 North*

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.