

FILED AUG 13 1941 24

Registration District No. 124

Primary Registration District No. 5779

Registrar's No. 26

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Rural (Byrd Twp)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Cape Girardeau Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
(Specify whether years, months or days)

3. (a) PRINT FULL NAME George W. Kelly
3. (b) If veteran, name war 3. (c) Social Security No. None

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Don't know 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Don't know
(Month) (Day) (Year)

8. AGE: Years about 93 Months Days If less than one day
hr. min.

9. Birthplace Don't know
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business
12. Name Don't know
13. Birthplace Don't know
14. Maiden name Don't know (State or foreign country)
15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature C. H. Randal
(b) Address Cape Girardeau Mo RR 2

17. (a) Periyville Mo (b) Date thereof 7-6-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Periyville Mo

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

19. (a) 7-5-41 (b) D. G. Leibert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cape Girardeau
(c) City or town Rural (Byrd Twp)
(If outside city or town limits, write "RURAL")
(d) Street No. Cape Girardeau Mo RR
(If rural, give location)
(e) If foreign born, how long in U. S. A. 5 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH Month July day 5th
year 1941 hour 11 A minute 00 A. M.

21. I hereby certify that I attended the deceased from 8 P.M. - 7-4, 1941 to 11 A.M. 7-6, 1941
that I last saw him alive on 7-4-41
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial asthma Duration 2H
Due to
Due to
Other conditions 11/2
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: not investigated

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 D. G. Leibert (M. D. or Nurse) MD
Address Jackson Mo Date signed 7-5-41

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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, above space should be left blank.