MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

9902

File No. 6474

Registered No.

1. PLACE OF DEATH

County

Township

City St Louis (No. 3914 N. 11th St. St. Ward

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME Lucille Kelley

(a) Residence. No. 3914 N. 11 St. 26 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mch 27-1909

7. AGE: Years 17 | Months 11 | Days 14 | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Patrick Kelley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Canada
(STATE OR COUNTRY) Ill

12. MAIDEN NAME OF MOTHER Ida Allen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Canada
(STATE OR COUNTRY) Ill

14. INFORMANT Patrick Kelley
(Address) 3914 N. 11th St

15. FILED MAR 12 1927 Mae C. Starkloff, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 11 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 4:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
Y.R.
Smoothing
M.M.A. (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) NO (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. W. Falk, M.D.

3/12, 1927 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Calvary Cem | DATE OF BURIAL: Mch 14 1927

20. UNDERTAKER: A. Kron & Nics | ADDRESS: 2707 N. Grand

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.

WRITE PLAINLY, WITH INK. DO NOT FOLD.