

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

Do not use this space.

12326

1. PLACE OF DEATH

County.....

Registration District No. **79H**

Township.....

Primary Registration District No. **10003**

City **St. Louis**

No. **1537 N. 8th (Rear)**

File No.

Registered No. **2044**

St.

Ward)

2. FULL NAME

Heleen Frances Kelleher

(a) Residence. No. **1537 N. 8th (Rear) 25** Ward.

(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)

Feb. 25 1929

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Homer Kelleher

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

12. MAIDEN NAME OF MOTHER

Heleen Brosky

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

14.

INFORMANT (Address)

**Homer Kelleher
1037 N. 8th**

15.

FILED

**Mar 27 1929
L. C. Standiford
REGISTRAR**

MEDICAL CERTIFICATE OF DEATH

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

Mar. 3, 1929

17.

I HEREBY CERTIFY, That I attended deceased from **Feb. 26** 1929, to **Mar. 3** 1929 that I last saw **her** alive on **Mar. 3** 1929, and that death occurred, on the date stated above, at **6:40 p. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Primary Bacterial Pneumonia

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **no.** DATE OF.....

WAS THERE AN AUTOPSY? **no.**

WHAT TEST CONFIRMED DIAGNOSIS? **clinical**

(Signed) **Wm. J. Donovan** M. D.

Mar. 4, 1929 (Address) 1943 N 11th St

*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 C.M.

DATE OF BURIAL

Mar. 5, 1929

20. UNDERTAKER

Gas. W. Clark

ADDRESS

**1125
Hodiamont
Ave**

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.

RECORD WITH CHANGING NUMBERS IS A PERMANENT RECORD

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