WRITE PLAINLY, WIYH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

35310

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. 214 Lombard St. ..... Ward)

File No. .....

Registered No. 10052

2. FULL NAME Emma Kelly

(a) Residence. No. 214 Lombard St. 22 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Adam Hofman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 2 - 1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	80	2	10	

8. OCCUPATION OF DECEASED

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

(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) Louisiana

PARENTS

10. NAME OF FATHER Benjamen Walker

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT William Hoffman (Address) 214a Lombard St.

15. FILED ..... 19.. Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 12th 1929

17. I HEREBY CERTIFY, That I attended deceased from 6/31/ 1929, to 10/12/ 1929 that I last saw h.. alive on 10/11/ 1929 and that death occurred, on the date stated above, at 1-30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

94A Angina Pectoris
87A

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (SECONDARY)* Nephritis

..... (duration) 2 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No. Clinical

WHAT TEST CONFIRMED DIAGNOSIS? No Hospital

(Signed) ..... M. D.

10/12/ 1929 (Address) 5251 Natural Bridge

*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	DATE OF BURIAL
Calvary	Oct 15 1929

20. UNDERTAKER	ADDRESS
Wacker Helderle	2331 So B'dway