

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

Do not use this space.

7292

1. PLACE OF DEATH

County _____
Township _____
City St. Louis

Registration District No. 791
Primary Registration District No. 1003
No. City Hospital #1

File No. _____
Registered No. 2189
St. _____ Ward)

2. FULL NAME

Charles Kelly
(a) Residence. No. S. W. 9th St. St. 25 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

Male

4. COLOR OR RACE

White

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

Unknown

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Unknown

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

alt 67

✓

✓

✓

8. OCCUPATION OF DECEASED

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

Waiter

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

Restaurant

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Texas

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT

(Address)

John J. Tierley
Foundry Office

15. FILED

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Mr. D. Starks

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-24-1930

The Physician in Attendance
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 _____, 5:02 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Lobar Pneumonia
106 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

MI (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Kemner M.D.

313, 1930 (Address) Dr. Crocker

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

18. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Totten Field 3-6-1930

20. UNDERTAKER

ADDRESS

Ziegenfuss Bros. Cherokee

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.

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