

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

Do not use this space.

34398

1. PLACE OF DEATH

County St. Louis Registration District No. 1123 File No. _____
 Township Carondelet Primary Registration District No. 6248-E Registered No. 331
 City St. Louis (No. 121 St. Rose Sanitation St. _____ Ward)

2. FULL NAME

Martin Kelley
 (a) Residence No. 2900 Trenchey St. _____ Ward. E. St. Louis Ill
 (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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Married, widowed or divorced specify the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 23-1914

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
19 1 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Edward Kelly

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

12. MAIDEN NAME OF MOTHER May Joan

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

14. INFORMANT Burke Und Co
 (Address) E. St. Louis Ill

15. FILED 9353 L. C. Obrock
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/23 1933

17. I HEREBY CERTIFY, That I attended deceased from 9/17/33, 1933 to 10/23, 1933 that I last saw him alive on 10/22, 1933 and that death occurred, on the date stated above, at 3:54 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary tuberculosis

Chronic myocarditis
 CONTRIBUTORY (SECONDARY)
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED Unknown

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Sputum X-ray

(Signed) John Williams M. D.

10/23/33 (Address) 9104 So. Bway

*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 East St. Louis Ill DATE OF BURIAL 10-20-1933

20. UNDERTAKER Burke Und Co. ADDRESS East St. Louis Ill

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 UNFADING INK—THIS IS A PERMANENT RECORD

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