

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.

APR 25 1934

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis,** (No. **3543a Wisconsin Ave.**) St. _____ Ward _____

File No. **11116**
Registered No. **2976**

2. FULL NAME

Sophia Kelly

(a) Residence, No. **3543a Wisconsin Ave.** St. **24** Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Divorced**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 9, 1890.**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
43 8 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **At home**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

13. NAME **John Benisch.**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Poland.**

15. MAIDEN NAME **Frances Klemanc**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Poland.**

17. INFORMANT (ADDRESS) **Dolores Kelly**
3543a Wisconsin Ave.

18. BURIAL, CREMATION, OR REMOVAL **Calvary Cemetery** DATE **Mar. 27, 1934.**

19. UNDERTAKER (ADDRESS) **J. N. Gibbons & Co.**
2842 Meramec St.

20. FILED **19** **J. H. Brebeck** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Mar. 23, 1934**

22. I HEREBY CERTIFY, That I attended deceased from **Mar 23, 1934**, to **Mar 23, 1934**
I last saw her alive on **Mar 23, 1934** Death is said to have occurred on the date stated above, at **11:45 P. M.**
The principal cause of death and related causes of importance were as follows:

apoplexy
stroke
stroke
Other contributory causes of importance: _____
Date of onset **3/23/34**

23. Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? **no**
If so, specify _____
(Signed) **Roll D. Wyban**, M. D.
(Address) **3665 So. Broadway**

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis* (No.....)

Registration District No. *791*
Primary Registration District No. *1003*

File No.....
Registered No. *2976*
St..... Ward.....

2. FULL NAME

(s) Residence, No..... St.,..... 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Div.*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov. 23, 1934*

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... I last saw him alive on 19... Death is said to have occurred on the date stated above, at... m.

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

The principal cause of death and related causes of importance were as follows:

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

Asphyxiation Date of onset

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

Cerebral
Other contributory causes of importance:
gastric

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19...
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

Manner of injury.....
Nature of injury.....

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19...

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

19. UNDERTAKER (ADDRESS) *W. J. Brown*

(Signed) *Robert O. Wilson*, M. D.

20. FILED *9-1-34* 19... *A. Bredeck* Registrar.

(Address) *366 S. B. Brewster*

SUPPLEMENTARY

REGISTERED BY LAW... MISSOURI STATE BOARD OF HEALTH

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