

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

4580
 Do not use this space.

REC'D MAR 13 1939

1. PLACE OF DEATH
 (a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003** Registered No. **1273**
 (c) City **St. Louis** (d) Street No. **City Hospital No. 1** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
D. 16064 **W.C.O** **William Kelleher**
 2. PRINT FULL NAME
 (a) Residence, No. **2347 Albion St. 23** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male	4. COLOR OR RACE white	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 28, 1876				
7. AGE YEARS 62	MONTHS 1	DAYS 9	If LESS than 1 day, hrs. or min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as saw mill, bank, etc. carpenter			
	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) Massachusetts				
FATHER	13. NAME Thomas Kelleher			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland			
MOTHER	15. MAIDEN NAME Nora Connolley			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland			
17. INFORMANT Hosp. Info M. Kent (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL PLACE St. Matthews DATE 2/19/39				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. J. Brennan 2929 S. Jefferson Ave				
20. FILED 19 Feb 9 1939 J. P. Budick Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2/7/39** 19...

22. I HEREBY CERTIFY That I attended deceased from **2/2/39** to **2/7/39**
 him **19/7/39** 19...
 I last saw him alive on **2/7/39** 19... Death is said to have occurred on the date stated above, at **6.50** m. p.
 The principal cause of death and related causes of importance were as follows:
Hypertensive heart disease, decompensated.

Other contributory causes of importance: **None**

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

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) **E. J. Dink** M. D.
 (Address) **City Hospital No. 1**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

Paul A. Hanklin

....., or by

Registered Apprentice No., working under my personal supervision.

Signed

Paul A. Hanklin

Licensed Embalmer No. *3472*

P. O. Address *215 S. 1st St.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.