

REC'D APR 12 1939

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

8310

Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City **St. Louis**

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

Registered No. **2075**

(d) Street No. **De Paul Hospital** 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.

2. PRINT FULL NAME **Baby Kelley**

(a) Residence, No. **1908 Cora Ave.** St. **11**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **—**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 3, 1939.**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
12 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. **—**
10. Date deceased last worked at this occupation (month and year) **—**

11. Total time (years) spent in this occupation **—**

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

FATHER
13. NAME **Joseph D. Kelley**
14. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Missouri**

MOTHER
15. MAIDEN NAME **Ruth Norma Rose**
16. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Missouri**

17. INFORMANT **Joseph D. Kelley**
(ADDRESS) **1908 Cora Ave.**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **Calvary Cem.** DATE **Mar. 4, 1939.**

19. FUNERAL DIRECTOR (NAME) **Wm. F. Paschedag**
(ADDRESS) **2825 N. Grand Blvd.**

20. FILE **MAR 4 1939** **W. F. Paschedag** Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **March 3, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **Mar 3rd**, 19**39**, to **Mar 3rd**, 19**39**
I last saw him alive on **March 3rd**, 19**39**. Death is said to have occurred on the date stated above, at **2:50P** m.
The principal cause of death and related causes of importance were as follows:

Not Verifiable
Baby Dined One hour

Date of onset

Other contributory causes of importance:

Placenta Praevia Birth

Name of operation..... Date of.....
What test confirmed diagnosis? **Inspection** Was there an autopsy? **No**

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?
If so, specify.....
(Signed) **W. F. Paschedag** M. D.
(Address) **2745 N. Grand Blvd.**

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF FUNERAL SERVICE

not embalmed CF

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,

or by

Registered Apprentice No., working under my personal supervision:

Signed

Licensed Embalmer No.

P.O. Address

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.