484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34026 8564

Registration District No. 791 — Primary Registration District No. — Registrar's No.

1. PLACE OF DEATH: 1003 /

(a) County

(b) City or town St Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Homer Phillips Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 9 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED: /

(a) State Missouri (b) County

(c) City or town St Louis Mo 21 (If outside city or town limits, write "RURAL")

(d) Street No. 2816a Dickson (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mary Francis Kelly

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race Col

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Milton J. Kelly

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Sept (Month) 25 (Day) 1890 (Year)

8. AGE: Years 49 Months 0 Days 8 If less than one day hr. min.

9. Birthplace Starksville (City, town, or county) Missipi (State or foreign country)

10. Usual occupation Nil

11. Industry or business /

FATHER
12. Name Unknown 0
13. Birthplace Unknown (City, town, or county) ? /

MOTHER
14. Maiden name Unknown /
15. Birthplace Unknown (City, town, or county) ? (State or foreign country)

16. (a) Informant's own signature Milton Kelly

(b) Address 2816a Dickson St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-39 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Ellis Funeral Home

(b) Address 2820 Stoddard St

19. (a) OCT 8 1939 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 3rd year 1939 hour 5:20 minute P. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage (Apoplexy); — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Deputy Coroner Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

MARGIN RESERVED FOR BINDING

50M-5-17-39 Rev. 5-17-39 I X19511

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 L. Boyk

....., Registered Apprentice No. Myself

working under my personal supervision.

Signed Lonnie Boykin

Licensed Embalmer No. 2946

P. O. Address St Louis Mo

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.)

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