DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34673

Registration District No. 791 | Primary Registration District No. | Registrar's No. 9211

1. PLACE OF DEATH: 1003

(a) County

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

(c) Name of hospital or institution:
St Louis Children's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)
In this community 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hunewell

(c) City or town Hunewell (If outside city or town limits, write "RURAL") WR

(d) Street No. (If rural, give location)

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

3. (a) PRINT FULL NAME John Lyman Kellogg

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife child

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

7. Birth date of deceased Sept (Month) 17 (Day) 1931 (Year)

8. AGE: Years	Months	Days	If less than one day
8	1	10	hr. min.

9. Birthplace Missouri (City, town, or county) Mo. (State or foreign country)

10. Usual occupation child

11. Industry or business child

FATHER
12. Name Gerard Samuel
13. Birthplace Lakenan (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Clara Wood
15. Birthplace Hunewell (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature C Evers
(b) Address 500 S. Kingshighway

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/29/39 (Month) (Day) (Year)
(c) Place: burial or cremation Hunewell, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington

19. (a) OCT 27 1939 (Date received local registrar) (b) J. Burdick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27 year 1939 hour Twelve minute five A.M.

21. I hereby certify that I attended the deceased from October 23, 1939 to October 27, 1939; that I last saw him alive on October 27, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Convulsions	7 days
Due to Brain abscess (non-tuberculous)	
Due to Cause unknown	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

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 Henry Schmand M.D.
Address 500 So. Kingshighway Date signed 10/27/39

(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.

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.....2971.....

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.