

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MAY 13 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37645
Registrar's No. 9484

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County 1
(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:
City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 23 Days
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4542a McMillan 12
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Amos Kelly 487
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month November day 5,
year 1939 hour 10:10 minute _____ P. M.
21. I hereby certify that I attended the deceased from October 14,
1939, to November 5, 1939
that I last saw him alive on November 5, 1939
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Leasie 6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased April 18 1894
(Month) (Day) (Year)

Immediate cause of death Chronic Pyelonephritis, Right non tubercular
Due to _____
Due to _____
Other conditions adhesions, Cerebral
(Include pregnancy within 3 months of death)

8. AGE: Years 45 Months 6 Days 18 If less than one day _____ hr. _____ min.

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Major findings: Of operations 110
Of autopsy _____

9. Birthplace Bloomfield, Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer

11. Industry or business _____
MOTHER FATHER { 12. Name John Kelley _____
13. Birthplace Stoddard Co., Missouri _____
(City, town, or county) (State or foreign country)
14. Maiden name Ma n Harper _____
15. Birthplace Stoddard Co., Missouri _____
(City, town, or county) (State or foreign country)

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

16. (a) Informant's own signature Ralph Kelley
(b) Address 4542a McMillan
17. (a) Removal (b) Date thereof 11/6/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Pleasant Valley, Mo.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.
19. (a) NOV 6 1939 (b) J. F. Budach
(Date received local registrar) (Registrar's signature)

23. Signature Amos Kelly (M. D. or other) _____
Address 1515 Lafayette, 11/6/39 Signed _____

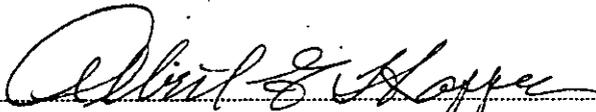
STATEMENT BY LICENSED EMBALMER

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. 5971

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.