

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 9202  
Registrar's No. 2685

Registration District No. 791

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Enroute Homer G. Phillips Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

8. (a) PRINT FULL NAME Delia Kelly  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 15 1880  
(Month) (Day) (Year)

8. AGE: Years 59 Months 9 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Redwood Miss  
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Grant Honey ?  
13. Birthplace Unknown ?  
(City, town, or county) (State or foreign country).  
14. Maiden name Delia Honey ?  
15. Birthplace Unknown ?  
(City, town, or county) (State or foreign country)

16. (a) Informant Beula Ross  
(b) Address 2948 Sheridan Ave

17. (a) Removed (b) Date thereof 3/24/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Onward Mississouri

18. (a) Signature of funeral director Ellis Funeral Home  
(b) Address 2820 Stoddard St

19. (a) MAR 22 1940 (b) J. J. [Signature]  
(Time received by registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis 21  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2948 Sheridan Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

No attending physician

20. DATE OF DEATH: Month March day 19th  
year 1940 hour 10 minute 00 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral 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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

**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. *L. Boyer*

..... working under my personal supervision.

Signed *Tommy Boyer*

Licensed Embalmer No. *2940*

P. O. Address *St. Louis*

**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.**