

Registration District No. **791**

Primary Registration District No. _____

Registrar's No. **4722**

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:
4242 Shaw Blvd. **2**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Minnie Kellerd **463**

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

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

7. Birth date of deceased May 1st 1882
(Month) (Day) (Year)

8. AGE: Years 58 Months 0 Days 28 If less than one day hr. _____ min. _____

9. Birthplace New York N.Y.
(City, town, or county) (State or foreign country)

10. Usual occupation H. W. K.

11. Industry or business _____

MOTHER FATHER { 12. Name Patrick Kellerd

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Ann McMahon

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Ann McMahon

(b) Address 4242 Shaw Blvd.

17. (a) Burial (b) Date thereof 6-1-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser Mortuar

(b) Address 4228 So. Kingshighwa

19. (a) MAY 29 1940 (b) J. F. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St. Louis **17**
(If outside city or town limit, write "RURAL")
4242 Shaw Blvd.
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29th
 year 1940 hour 5:25 minute 4 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 _____
Chronic Interstitial Nephritis

Due to _____
Chronic Interstitial

Due to _____
Nephritis

Other conditions (Include pregnancy within 6 months of death) _____

Major findings: _____
 Operations: _____
 Of autopsy: Brain

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 [Address] Date signed 5/29/40

PHYSICIAN

 Underline the cause to which death should be charged statistically.

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.....
working under my personal supervision.

Signed

Edwin J. McDevitt

Licensed Embalmer No.

3024

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.