

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7893**

**1. PLACE OF DEATH:** **St. Louis Mo.**

(a) County. \_\_\_\_\_

(b) City or town. \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **DePaul Hospital**  
(If not in hospital or institution, write street number or location) **1**

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

In this community \_\_\_\_\_ years, months or days)

**3. (a) PRINT FULL NAME: Baby Kelly**

**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: \_\_\_\_\_**

**6. (b) Name of husband or wife: \_\_\_\_\_** **6. (c) Age of husband or wife If alive: \_\_\_\_\_ years**

**7. Birth date of deceased: Sept. 21, 1940**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<b>1</b>	hr. _____ min.

**9. Birthplace: St. Louis, Mo.**  
(City, town, or county) (State or foreign country)

**10. Usual occupation: \_\_\_\_\_**

**11. Industry or business: \_\_\_\_\_**

**12. Name: Anthony Kelly**

**13. Birthplace: Mo.**  
(City, town, or county) (State or foreign country)

**14. Maiden name: Ruth Knobloch**

**15. Birthplace: Mo.**  
(City, town, or county) (State or foreign country)

**16. (a) Informant: Mr. Knobloch**

**(b) Address: 4970 Ashby**

**17. (a) Burial (b) Date thereof: 9/23/40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation: Memorial Park Cem.**

**18. (a) Signature of funeral director: Sullivan Und. Co.**

**(b) Address: 2849 N. Euclid Ave.,**

**19. (a) SEP 22 1940 (b) J.F. Knobloch**  
(Data received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **MO.** (b) County \_\_\_\_\_

(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL") **7**

(d) Street No. **4970 Ashby**  
(If rural, give location)

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

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH: Month: SEPT day: 22**  
year: **1940** hour: **12** minute: **15** A.M.

**21. I hereby certify that I attended the deceased from Sept 21**  
**1940, to Sept 22, 1940.**  
that I last saw her alive on **Sept 21, 1940**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Prematurity**

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

Duration \_\_\_\_\_

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)  
Cause of injury \_\_\_\_\_

**23. Signature: John G. McInerney M. D. or other: MD**  
Address: **5014 Thebes Ave** Date signed: **9/23/40**

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

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**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

*Albert Mayfield*  
\_\_\_\_\_

Licensed Embalmer No. *307*

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**