

NOV 16 1940  
Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8147

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution: St. Louis City Hospital  
(d) Length of stay: In hospital or institution 3 years, months or days (Specify whether)

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

4. Sex male 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 February (Month) (Day) (Year)

8. AGE: Years 74 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Laborer

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

MOTHER FATHER  
12. Name Antonia  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Albert Meier  
(b) Address 4255 Oakland

17. (a) \_\_\_\_\_ (b) Date thereof 1-17-40 (Month) (Day) (Year)  
(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. Kuhw 3000 Rte 5  
(b) Address \_\_\_\_\_

19. (a) 1 1940 (b) J.F. Brudick (Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County \_\_\_\_\_  
(c) City or town St. Louis 25 (If outside city or town limits, write "RURAL")  
(d) Street No. 911 Market (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 4  
year 1940 hour 7:45 minute A 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 Occlusion Duration \_\_\_\_\_

Due to Cerebral Occlusion

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

Major findings: Of operations AK 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)  
(c) Means of injury 5  
23. Signature Joseph M. Quinn (M. D. or other) \_\_\_\_\_  
Address Deputy Coroner Date signed \_\_\_\_\_

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.....

Licensed Embalmer No.....

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.**