

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33882
Registrar's No. 8579

Registration District No. 791

Primary Registration District No.

1. PLACE OF DEATH:

- (a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 hours
(Specify whether
In this community.
years, months or days)

3. (a) PRINT FULL NAME Robert Kelley

8. (b) If veteran, name was Spanish-Amer. 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bertha A. Thiele 6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased June 17, 1877
(Month) (Day) (Year)

8. AGE: Years 63 Months 4 Days If less than one day
hr. min.

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

10. Usual occupation Mgr. Laundry Barnes Hospital

11. Industry or business

12. Name John Thos. Kelley
13. Birthplace Ind.
(City, town, or county) (State or foreign country)
14. Maiden name Hannah Gough
15. Birthplace Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bertha A. Kelley

(b) Address 1259 Roland Dr.

17. (a) Removal (b) Date thereof 10/18/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Booneville, Ind.

18. (a) Signature of funeral director [Signature]

(b) Address Clayton Rd. at Concordia Lane.

19. (a) OCT 17 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MISSOURI (b) County Richmond
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1259 Roland PLACE
(If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 17
year 40 hour 3 minute A M.

21. I hereby certify that I attended the deceased from 10
16, 1940, to 10 17, 1940;
that I last saw him alive on 10 17, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Sub-arachnoid hemorrhage Duration 6 hrs.

Due to Essential Hypertension

Due to [Signature]

Other conditions [Signature]
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Sub-arachnoid hemorrhage & beginning nephritic arthritis

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 FR Bradley (M. D. or other)
Address BARNES HOSPITAL Date signed 10-12-40

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. 1994

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.