

FILED JAN 15 1940 911

Registrar's No. **10213**

Registration District No. \_\_\_\_\_

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: Bethesda Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 32 days  
In this community 9 yrs 10 mo 21 days (Specify whether years, months or days)

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

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

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

7. Birth date of deceased 1 17 31  
(Month) (Day) (Year)

8. AGE: Years 9 Months 10 Days 21 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation School girl

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

12. Name Elmer Kelly

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

14. Maiden name Evelyn Wright

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

16. (a) Informant Mother - Eschm Kelly

(b) Address 1017 Park Ave.

17. (a) Burial (b) Date thereof Dec. 12 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Matthews

18. (a) Signature of funeral director G. W. McLaughlin

(b) Address 2317 Lafayette St. Fair

19. (a) DEC 12 1940 (b) J. F. Breder  
(Date of local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) St. Louis  
(c) City or town St. Louis - 23  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1017 Park Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10  
year 1940 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from Sept. 1, 1935 to Dec. 10, 1940;  
that I last saw her alive on Dec. 9, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Endocarditis, septic  
Duration 30 days

Due to 127  
Due to \_\_\_\_\_

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

Major findings: Splenomegaly  
Of operations: Cholecystitis, no clones  
Of autopsy: Not performed

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 1

23. Signature T. S. Schrosky (M. D. or other)  
Address 536 N. Taylor Date signed 12/12/40

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

MOTHER FATHER

**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 *L. R. Casper*

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

**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.**